HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Faye G. Abdellah

FAYE G. ABDELLAH

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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Faye G. Abdellah

CHRONOLOGY

1919	Born New York City, March 13
1942	Fitkin Memorial Hospital School of Nursing, Neptune, NJ, R.N.
1942-1944	Rutgers University, student
1942-1943	Child Education Foundation, New York, NY, Director of Health Services
1943-1945	Columbia Presbyterian Medical Center, New York, NY, Staff Nurse/Head Nurse
1945	Columbia University, Teachers College, B.S.
1945-1949	Yale University School of Nursing, Instructor
1947	Columbia University, Teachers College, M.A.
1948-1949	Columbia University, Teachers College, Research Fellow and Teaching Assistant
1949-1954	U.S. Public Health Service, Division of Nursing Resources, Bureau of State Services, Chief, Nurse Consultant
1954-1955	U.S. Public Health Service, Division of Nursing Resources, Bureau of State Services, Chief, Nursing Education Branch
1955	Columbia University, Teachers College, Ed.D.
1955-1958	U.S. Public Health Service, Division of Nursing Resources, Bureau of State Services, Senior Consultant, Nursing Research
1957-1958	Western Interstate Commission for Higher Education (WICHR) Nurse Consultant

CHRONOLOGY - (Continued)

1958 (two months)	University of Washington, Seattle, Visiting Professor
1958-1960	U.S. Public Health Service, Division of Hospital and Medical Facilities, Progressive Patient Care Project, Principal Investigator
1959 (two months)	University of Colorado, Boulder, Visiting Professor
1960 (two months)	University of Minnesota, Visiting Professor
1960-1961	U.S. Public Health Service, Division of Nursing, Bureau of State Services, Research Grants Branch, Assistant Chief
1961-1968	U.S. Public Health Service, National Institutes of Health, Division of Nursing, Bureau of Health Manpower Education, Research Grants Branch, Chief
1963-1968	U.S. Public Health Service, National Institutes of Health, Division of Nursing, Bureau Manpower Education, Research Grants Branch, Chief
1963-1968	U.S. Public Health Service, National Institutes of Health, Division of Nursing, Bureau of Health Manpower Education, Nurse Scientist Graduate Training Committee, Executive Secretary
1969-1970	U.S. Public Health Service, National Center for Health Services Research & Development, Office of Research Training, Director
1970-1981	U.S. Public Health Service, Assistant Surgeon General,

	Chief Nurse Officer
1970-1972	U.S. Public Health Service, National Center for Health Services Research & Development, Associate Director
1971-1973	U.S. Public Health Service, National Center for Health Services Research & Development, Acting Deputy Director
1973-1976	U.S. Public Health Service, Office of Nursing Home Affairs, Director
1976-1977	DHEW, Office of the Secretary, Special Assistant to the Under Secretary for Long-Term Care
1977-1979	U.S. Public Health Service, Chief Advisor on Long-Term Care Policy to Deputy Assistant Secretary for Health Planning and Evaluation
1981-1982	U.S. Public Health Service, Acting Director, Office of the Deputy Surgeon General
1982-	U.S. Public Health Service, Deputy Surgeon General

CHRONOLOGY

(International)

1969	Yugoslavia, Official Health Delegation, Member
1970	Russia, Official Health Delegation, Member
1972	France, Official Health Delegation, Member
1974	Multinational Study on the International Migration of Physicians and Nurses, WHO Research Consultant
1976	World Health Assembly, U.S. Delegation, Member
1976	Portuguese Government, Consultant on Development of Programs for the Care of the Elderly and Disabled
1976	Tel Aviv University, Israel, Consultant on Setting Up Nursing Research Program
1977	Japanese Nursing Associations, Consultant on Setting Up Graduate Programs in Nursing Education and Research
1978	People's Republic of China, Member of the National Council of Health Care Services on A Visit to the Care of the Elderly and Mentally Retarded
1979	World Health Assembly, Geneva, U.S. Delegation, Member

AFFILIATIONS & MEMBERSHIPS

(Present and Past)

American Academy of Nursing, Fellow

American Association of the Advancement of Science, Member

American Heart Association, Member Council of Cardiovascular Nursing

Subcommittee for Preparing and Establishing Criteria for Research

American Nurses Association, Member, President, Vice President

Council of Nurse Researchers

American Nurses Foundation, Member

Board of Trustees

American Psychological Association, Fellow

American Public Health Association, Member

Gerontological Society, Member

Inquiry Editorial Board, Member

W.K. Kellogg Foundation National Advisory Board, Member

National Academy of Sciences, Member

National League for Nursing, Member

Advisory Committee on Research and Studies

Council on Research

History Committee on Archives

State Board Test Pool Examination Research Steering Committee

National Library of Medicine

Board of Regents (Representing the Surgeon General)

AFFILIATIONS & MEMBERSHIPS

(Present and Past)

New York Academy of Sciences, Member

Nursing Research Editorial Board, Member

AWARDS AND HONORS

Rutgers University

Four Year Scholarship, 1942

Pi Lambda Theta

National Honor and Professional Association in Education, 1955

Army Nurse Corps

Honored for Contributions to Nursing Education and Research, 1963

Association of Military Surgeons of the United States

Federal Nursing Service Award, 1964

Case Western Reserve University

Doctor of Laws, Honorary, 1967

Sigma Theta Tau

National Honor Society of Nursing, 1968

Columbia University, Teachers College, Nursing Education Alumni Association

Award for Distinguished Achievement in Research and Scholarship, 1969

National Defense Service Medal, 1970

Ohio State University

Centennial Award for Achievement in Nursing Research, 1970

USSR Academy of Sciences

Nickolai Ivanovich Pirogov Medal, 1970

Who's Who of American Women, 1970

Ann May School of Nursing Alumni Association

Helen J. Evans Award, 1971

U.S. Department of Health Education and Welfare

Distinguished Service Honor Award, 1973

Rutgers University

Doctor of Laws, Honorary, 1973

Columbia University, Teachers College

Medal for Distinguished Service, 1974

New Jersey State Nurses' Association

Hall of Fame, 1974

Who's Who in Government, 1974

U.S. Department of Health, Education and Welfare

Secretary's Certificate for Outstanding Performance, 1976

U.S. Department of Health, Education and Welfare

Certificate of Appreciation, 1977

American Health Care Association

Better Life Award, 1977

Association of Military Surgeons of the United States

Founder's Medal, 1977

U.S. Department of Health, Education and Welfare

Secretary's Certificate of Appreciation, 1977

University of Akron

Doctor of Science in Nursing, Honarary, 1978

American Public Health Association

Distinguished Service Award, 1978

American Journal of Nursing

Book of the Year Award, 1979

Columbia University, Teachers College, Nursing Education Alumni Association

McManus Medal for Distinguished Service to Nursing, 1980

U.S. Department of Health, Education and Welfare

Secretary's Certificate of Appreciation, 1980

U.S. Public Health Service, International Year of Disabled Persons

Distinguished Service Award, 1981

Catholic University of America

Doctor of Science, Honorary, 1981

Sigma Theta Tau

Excellence in Nursing Award, 1982

Monmouth College

Doctor of Public Service, Honorary, 1982

Federally Employed Women, Inc., Suburban Maryland Chapter,

Distinguished Service Award, 1982

Eastern Michigan University

Doctor of Science, Honorary, 1982

University of Arizona

Distinguished Citizen Award, 1983

BOOKS

Effect of Nurse Staffing on Satisfactions with Nursing Care

American Hospital Association, 1958

Better Patient Care Through Nursing Research (with Eugene Levine)

Macmillan, 1965, 1979

Patient Centered Approaches to Nursing

Macmillan, 1969

New Directions in Patient-Centered Nursing: Guidelines for Systems of Service, Education, and Research (with others)

Macmillan, 1973

Intensive Care Concepts and Practices for Nurse Specialists

(with others, eds.) Charles Press, 1969, 1975

WEEKS:

Dr. Abdellah, this is a question I often ask people in the health care field. How did you happen to become a nurse?

ABDELLAH:

It was a very exciting and dramatic experience for me. I was in high school at the time and during the disaster of the Hindenburg, with their marvelous Graf Zeppelin. I happened to see it go across and I thought what a marvelous way to travel, and I had not international exposure then. Then within a half an hour, we heard the ambulances and a call for anyone who could help. I recall my brother and I rode out to Lakehurst, N.J., which was only about nine miles away, but you could still see the smoke and everything. We tried to help.

Of course, being in high school, I had no formal training in nursing and I was very inadequate because most of the individuals who did survive were badly burned and the need to really give them immediate attention was quite evident. Obviously, there was not enough emergency help there. So we did what we could to provide what comfort we could. I realized that if I only knew how to take care of burns and what to do to relieve them and give them some relief from pain, I would be able to help. This left a very deep mark

upon me and I felt I really had to learn how to help people. I felt nursing was a calling.

I wanted very much to be responsive to that. From that time on I really set my sights to moving into professional nursing and becoming qualified to work with people.

WEEKS:

You did your first training where?

ABDELLAH:

My first training was at what was then the Ann May School of Nursing and has since become the Fitken Memorial Hospital, which is now a medical center. At that time, that was an accredited diploma program. There were very few baccalaureate programs.

So unlike some of my more recent colleagues, where one can go into baccalaureate nursing immediately, the opportunities were very limited then. Most professional nursing was available in diploma type programs. Fortunately, there happened to be a good diploma program there, but my academic education in terms of the liberal arts and so forth, followed after that.

WEEKS:

You did win a scholarship?

ABDELLAH:

Yes, I did win a scholarship for liberal arts at Rutgers University which was very exciting and did provide an opportunity for me to get into the liberal arts part of training.

WEEKS:

Then as I remember, you continued your education at Columbia.

ABDELLAH:

Yes, at Columbia, at Teachers College. I got as much as I could of the basic requirements in the liberal arts nd then went on to Teachers College. That was focused specifically on (and more opportunities were there) for getting into graduate nursing. At that time, that was the area that was most attractive to nurses.

WEEKS:

You stayed on for your doctorate which was a little unusual then for someone in nurse's training.

ABDELLAH:

What I did, when I finished my bachelor's degree in 1945 even during the time, I worked on my bachelor's, I worked part time at the child health education foundation which was on the east side of New York and operated a dispensary for the students who were there. It wasn't so demanding but it gave me an opportunity to maintain my clinical skills.

My first teaching post was, after my bachelor's degree, at the Yale University School of Nursing and I continued to work on my master's degree concurrently, during the summers and whatever.

The Yale experience was a highlight in my career. I spend almost five years there. That school, for its time, was very progressive because they only admitted students who already had a baccalaureate degree, and in a variety of fields. A degree might be in music, science, philosophy. The students were lots of fun to work with and very challenging. I remember feeling many times inadequate as a teacher because some of those students had four years of basic sciences. We learned to work together as a team and had great admiration for the faculty there and the students.

I realized that as to the direction in nursing, in terms of any changes in practice, that one had to be very well grounded in science, in philosophy, and in physiology particularly. In planning my doctorate, I felt that I should combine the physiology and possibly educational psychology to get both the biological science as well as the behavioral, to get some combination there. That, too, was a period when there was only a handful of nurses with doctoral preparation and there was no federal support for doctoral preparation so one had to seek one's own support. There were very few opportunities for nurses in graduate education. One had to seek graduate preparation in allied fields, because there was no so called Ph.D. in nursing at that time. Looking back, it is interesting to see the evolution and how that was developed. Later on I did have an opportunity to shape some of that.

WEEKS:

Was this the time when Professor Winslow was still alive and in the School of Public Health at Yale?

ABDELLAH:

I think he had just retired. I don't recall that he was the key leader then, although he had a very dramatic part in it.

WEEKS:

The reason I ask, last December I talked with Dr. Falk.

ABDELLAH:

Yes, Falk was there, definitely.

WEEKS:

And Jim Hamilton was at the hospital?

ABDELLAH:

Although the person I got to work with most was Albert Snoke. Jim

Hamilton I didn't know as well.

WEEKS:

Snoke spent his whole professional life there didn't he?

ABDELLAH:

Pretty much. I worked more closely with him and Jim Hamilton, somewhat.

WEEKS:

This is just an aside, but it is interesting to try to put different people in their settings.

ABDELLAH:

It is, Falk was there during the period I was there.

WEEKS:

After 1949, what then?

ABDELLAH:

1949 was when I became interested in the Public Health Service.

WEEKS:

In the meantime you had gone back to Columbia?

ABDELLAH:

That one year I did some part-time teaching and then completed my residency period for my doctorate and did some work supervising some student teachers particularly at the New York Rehabilitation Center. I had an opportunity there to work with people like Howard Rusk who was a great leader and is still alive, which is marvelous. He has been very active this year particularly in the International Year Conference. So that was a very good opportunity there to work with nursing at another level.

WEEKS:

Then, of course, we ask the same standard question again: How did you

happen to go into the PHS?

ABDELLAH:

One of my mentors who got me interested in research was R. Louise McManus, who was, when I was at Columbia University, the director of the nursing program there, and one of the pioneers in nursing research, particularly in patient care research. So we struck off a common note in that I was interested in doing research with patients. At that time, at Columbia, much of the research done by nurses was pretty much in the curriculum of nursing education. So this was a first effort; with her support, I was able to get into some patient care research.

She introduced me to Lucille Petry Leone, who at that time, in 1949, was the first chief nurse officer of the PHS and Assistant Surgeon General at Rear Admiral rank. That was during the time that Thomas Parran was the Surgeon General. I had my first interview with her and became very interested in opportunities there to work at a national level.

WEEKS:

I never met Thomas Parran, but Walt McNerney has spoken so highly of him because they were together in Pittsburgh.

ABDELLAH:

Wasn't that a team. Parran was a great man and really a great leader in his time.

WEEKS:

He inspired a lot of people...he was an active man, wasn't he?

ABDELLAH:

Very active, and he worked very closely with Mrs. Leone in a team relationship and I believe really established a very important precedence, in

terms of the health professionals teams working together. He was a very fine example.

WEEKS:

Then in 1955 you received your doctorate?

ABDELLAH:

Since I had completed my residency there, I did continue to work and actually did my research, mostly at that time because I had no federal support and I was working. I had an opportunity to collect my data at the clinical center in the neurological center. I was really trying to develop a patient theory in terms of looking at the very overt and covert problems in relation to neurological patients, and looking at those problems which were quite evident as well as many problems which were not identified by the health team.

So I had an opportunity there to use the neurologic patients from the center and also the psychiatric unit at the University of Maryland, where they did have two units with patients with psychosomatic illness which was for me an opportunity to look at still another type of patient, where health problems were evident, but one really didn't know the underlying cause.

WEEKS:

Your psychological training certainly helped you there, didn't it?

ABDELLAH:

Yes, it did.

WEEKS:

I've looked at your CV and the impact of your job contributions. Could we run down those? I was wondering about your 1949 to 1957 experience in nursing research and nursing education in fourteen states, I think you mentioned.

ABDELLAH:

That was one of my first assignments, to work with states and to begin to develop a methodology for determining nursing service and nursing education needs. One of my first assignments was in the state of South Carolina.

Going into that state, I recall so well, I was really scared to death. There was so much I had to learn. Although I had developed some research skills, it was indeed an opportunity to look at the total state. I felt that I really was accepted after the representative who headed up the local Chamber of Commerce introduced me one day to a large assembly. He said, "I want to assure you that the Chamber will be behind you all the way." I had gone through the state and we always joked about that...having the Chamber available.

But it was an opportunity to look at the state during that time, in 1950. Nursing education in the state of South Carolina at that time was very restricted, to say the least. It was pretty much in the diploma area. I remember at Columbia Hospital in Columbia, S.C., that the hospital administrator there had developed his own curriculum and was granting what he called his degree. So we, interestingly enough, even in the '50s had individual schools granting degrees without really going through the accrediting system.

WEEKS:

That was quite common, wasn't it throughout the country?

ABDELLAH:

Particularly in some of the southern states where there was quite a resistance to any university education.

WEEKS:

I remember talking with nursing directors in Michigan who said that they had to have their in-service educational courses because nurses coming from different schools were capable of doing different things and maybe not capable of doing all the things the hospital thought they should do. So this made a reeducation process necessary.

ABDELLAH:

Very much so, and it was interesting that parallel to that period the PHS under Mrs. Leone's leadership at the time was developing some guidelines for schools in developing curriculum, in terms of commonalities across the board, uniform definitions and also guidelines in terms of schools, how they should be set and be working with accrediting bodies.

That was the early role of the PHS, in helping schools. This was an unusual role because usually the federal government does not get into such direct action with schools.

WEEKS:

How did you implement your suggestions, say in South Carolina?

ABDELLAH:

What we did--this was a pattern we had used in other states--early on we realized we wouldn't get any place if this was the federal government coming in and dictating to them what was needed. So we set up an advisory council made up pretty much from leaders of the state. We had hospital administrators, physicians, pharmacists, a really multi-health discipline, and of course, nursing leaders, both service and education. Essentially I served as staff person to them and provided them...we would talk about the kinds of data we would need, what kinds of baseline information for planning. I would actually go out and set up the form and work with state agencies and collect

the information or have the agency provide it in a uniform way. Not in the very first survey, but in some of the later states, I had developed a little more sophistication. I was able also to set up some demonstrations of staffing pattern. Not only did we say, for an example, this would be an appropriate kind of staffing pattern but where we could really work with a sample of hospitals and set up some demonstration units. That proved to be quite effective. Again it was a sharing and a learning together, so it wasn't just giving them a package.

We had a formal report for each of these with specific recommendations prioritized, but the report itself didn't mean very much unless there was some follow-up to that. By setting up and continuing to work with the leaders in the state, I felt that had a much more lasting payoff, rather than just handing them a report.

WEEKS:

It must have been a test of your diplomatic skills.

ABDELLAH:

Yes, it was good training in national experience for one, and really very, very exciting...and quite different in various states and how they would approach it. For example, in the South and some of the eastern states they were perhaps more conservative, more traditional in their approach. Then working with some of the western states, it was quite a different attitude.

WEEKS:

And your being from the North too.

ABDELLAH:

Yes, quite different approaches. I think one of the lessons I learned from that was that health services delivery is essentially a team effort and

you can't just go into a state and look at nursing; you've got to look at service and the function and look at the total delivery and look at the different populations to be served. That was a real lesson to be learned, too. What applies in South Carolina, you can't automatically apply in New Jersey.

It was a lot of fun, I really loved it.

WEEKS:

Was your experience with the Western Interstate Conference different?

ABDELLAH:

Now that didn't come along until '57 and certainly the early work, working with individual states was a tremendous help in that I had learned from that early experience.

I had learned the kind of nucleus staff you have to have, the kind of input and support, what kind of agency support at the state level as well as the local level...and not only hospital nursing but community health and really the total picture. So that really helped me so much in the Western Interstate Commission.

I had the opportunity the year I was out there to work with thirteen western states. At the time, they did have a compact group for medicine and for dentistry and the compact group provided, working through the Western Interstate Commission, the use of common management and sharing. For example, instead of setting up a medical school in the thirteen states, through this compact arrangement, the students could go to school, like say, if they didn't have a medical school in Nevada, they could go to school in one of the states of the region on a cooperative arrangement. So you don't have to duplicate facilities, you began to share faculty and it made it possible for candidates

to move from one state to the other.

When I went out there, there was nothing like that for nursing, so there was a challenging opportunity. Working with the thirteen states to see what we could set up in terms of a shared training, service, leadership training kind of thing. So the thirteen states worked as a compact group and shared things on a cooperative basis so that whatever they shared, whether it was formal or whether it was continuing education and so forth, one looked at the total region rather than at one particular state.

Interestingly enough, the person I recruited for, Jo Eleanor Elliott, followed me there and was there for some twenty-three years. Now, interestingly, she in 1981 joined and became the chief of the Division of Nursing in the Bureau of Health Manpower in the PHS, so it was sort of a complete cycle there.

WEEKS:

Isn't it wonderful though that she could bring all of that experience into this new job?

ABDELLAH:

Yes, and doing it very effectively.

WEEKS:

It would seem to me, looking from the outside and from the publications I've seen from the Western Interstate Conference, this is also developing the idea that a group of states can cooperate and can do things together much more efficiently than separately. This could extend to other things besides health, I'm sure.

ABDELLAH:

Very much, in fact there have been some efforts, just about two years ago, applying it to the care of the elderly, for example, in the state of

Connecticut. I worked with June Quinn, who set up the so-called "first triage project," which was a coordination of health services for the elderly. So that, instead of having the older person going around shopping for the service, it was brought and made available. It was essentially the same kind of sharing arrangement. That just happened to be in one state, but it does have implications for other areas.

WEEKS:

Is that research group that Don Riedel was interested in back in Connecticut before he went to Washington, is that still functioning?

ABDELLAH:

I believe so.

WEEKS:

I haven't seen any publication recently.

ABDELLAH:

Not recently, but I believe so, it was very active.

The Western state experience...We established the Western Council on Higher Education in Nursing, sometimes referred to as WCHEN, which has through the years subsequently been a good testing ground for trying out different models of education and also predicting staff. It also stimulated other regional compact groups such as the New England Board of Education, NEBE as we call it, which had nursing as a major component and then the very early one at the Southern Regional Educational Board, (SREB) and the most recent one was out in Michigan, based now in Indianapolis, that is referred to as MAIN. It brings together thirteen states in the Midwestern Alliance in Nursing, which is similar to the regional compact group, WCHEN.

WEEKS:

I was impressed with the number of nurses that you have trained in the western region.

ABDELLAH:

Yes, we had quite a number who went through the system and it was helpful in exposing them to several guides and manuals. Our whole purpose in that was to train the leaders so that they could go back home to help.

WEEKS:

With all this you linked the need for research?

ABDELLAH:

Yes, this is where I could see the great need for the development of research and to prepare research.

WEEKS:

May I ask this question...it seems to me that back 20 years ago nursing research was not being done by nurses, in the majority of cases.

ABDELLAH:

Your perception is absolutely right.

WEEKS:

And now you are turning this around, hopefully?

ABDELLAH:

Yes, we see the change, I'd say during the 1950s and 1960s that much of nursing research was done by the social scientists, behavioral scientists, and there was a good reason for this. We just didn't have nurses prepared and it wasn't until '55 that we started any sizable federal program for the training of nurses in nursing research.

So that we had to turn to other disciplines. Also, the industrial engineers. Some of the people, like Charlie Flagle, got very much interested

in staffing and that kind of thing.

But it wasn't until the 1970s that you began to see some results, where nurses were directing research. You find it much more related to the patient. Of course, that's the most difficult kind of research.

It is a lot easier to do role studies, attitude studies, and that kind of thing. To really get into patient care research, nurse researchers realize you have to have the basic science preparation and you really have to have much more sophistication in terms of experimental design, etc. As nurses became prepared, you could begin to see the shift and more attention to patient care or client research.

WEEKS:

I remember when Florence Alexander came to Michigan from AMA, she was very hopeful that she could get some real research going but I think was quite disappointed because it didn't work out for some reason, organizational reasons. But then, I think she inherited quite a lot of money so that she retired, I believe quite early.

ABDELLAH:

But, that is a very good point, that we realize that if one nurse researcher goes into a setting, if she doesn't have an environment for nursing research or the support from top management, it is very difficult. So Florence was right in that respect. You have to create the environment.

WEEKS:

Here again, Florence was a Ph.D. She had an adjunct teaching arrangement with the School of Nursing, but the School of Nursing was directed by a lady who did not have her Ph.D. and who felt threatened. This made it very difficult and Florence's hands were tied and she could not do much through the

school.

ABDELLAH:

You know, one of the things I am most proud of is that I was able to get started what we call a faculty research development grant. That really had a lot of spinoff.

I got so annoyed one day when a Dean of a School of Nursing said to me "I don't know why you get so concerned about nurses doing research and having time for them to do research. Why, they can do that on their lunch hour." I thought about it and I was just so upset about that.

I was talking about faculty research development grants. I realized how important environment was to stimulate research. Faculty research development grants provided support for faculty release time to do research and to give some support for whatever the project they would be on.

We started and had an advisory group for that. We started at what is now Case Western Reserve and a few other centers: the University of Washington, New York-Cornell, and at Wayne University where there was already some need and interest in that.

We were able to get some of that started. Eventually there were about twenty-five programs interested. That had a lot of spinoff in terms of a lot of the faculty had release time, whether it was just a day, it was release time. This was their day. It also directed them back to the patient.

WEEKS:

This was a marvelous thing about research of this type.

ABDELLAH:

Yes. It was unlike some of our European counterparts where the faculties in those schools would not get involved in clinical practice.

Although a few universities now with nursing are beginning to require that you spend a day or two in clinical setting, not just in academia, and combine the two. I think that has a great deal to do with it.

The faculty development grants did push the faculty back into the clinical setting, to do their research. This opened up all kinds of things. So what they would do--they would participate in the faculty research development and it would give them time to develop research protocol. Then some of them would come in and actually apply for a grant to carry out the research in more depth. Might even start with an exploratory study or something similar. So that helped a great deal.

WEEKS:

The fact that they were raising questions, looking for answers to problems...this is wonderful.

ABDELLAH:

The other thing that had a spinoff too, was we realized we had to encourage a forum where nursing research could be presented. One of the early research grants went to the American Nurses Association and later to the Western Interstate Commission for Higher Education which sponsored nursing forums. This provided an opportunity for nurse researchers to present their study and to be critiqued by their peers.

This, for nursing, was quite a revolutionary experience, to get up there and really have your research critiqued was not always the most kind experience, but it was a very good stimulating one and I think it did stimulate a lot more sophistication in the quality of the research that was being developed.

WEEKS:

And to get the rank and file nurses to begin thinking in terms of research and accepting this as part of their profession was an important advance.

ABDELLAH:

Yes, at that time, when I didn't have as many involvements as today, it was possible for three or four summers, I spent six weeks each summer as a visiting professor at the University of Washington, the University of Minnesota, and the University of Colorado with the specific purpose of working with the faculties there. They would invite others from that region and get them interested in research and stimulate them in some small projects and guide them on later on.

Those were very rewarding periods, but again, it was an effort to help nurses to feel more comfortable in doing research and also to communicate to our colleagues in medicine and hospital administration that it was quite appropriate for nursing to get into research. So that stimulated a lot of back and forth and began to get more interest in the area.

Fortunately, at that time, beginning in '55, there was a parallel interest at the federal level in developing and getting support for nursing research.

WEEKS:

Someone made the statement, I think it was George Bugbee, that when Eisenhower became president, with all the talk that had been going on about the Wagner-Murray-Dingell bill and national health insurance, that the Republicans, particularly we'll say President Eisenhower, didn't feel that this was the time to go ahead any further with anything like a national health insurance but thought that the approach should be to spend more money in research. The way George says, this meant that millions of dollars became available for research which had not been there previously. Is that a fair statement?

ABDELLAH:

That is a fair statement. It is interesting that it was during a Republican administration that we really got our start and you may be interested to know that at that time our nursing research component was a part of the National Institutes of Health, which is one of the six agencies of the PHS.

Our early supporters, believe it or not were, Michael DeBakey, and Mary Rockefeller, who was on the advisory council (Nelson Rockefeller's first wife, Mary Clark Rockefeller). She was a great supporter.

WEEKS:

Now this was before HEW - before '53?

ABDELLAH:

No, it was in '55...'55-'56.

WEEKS:

Rockefeller was still in?

ABDELLAH:

Under Oveta Culp Hobby, yes that was in '53...this was a little bit later, couple of years or so. But they were the first ones who really said "Why not? Why shouldn't nurses be doing research?" And also on that was R. Louise McManus. I have mentioned her earlier as one of my mentors.

They formed a small nucleus of that National Advisory Council. They were very supportive in helping us establish a nursing research study section and were very understanding in terms of the fledgling type research that would come in. Some of those very sophisticated scientists would view nursing research as rather mundane. Some of it came in and we got it supported, a lot of it. They were of enormous help at the time.

WEEKS:

This is the first I've heard that Mrs. Rockefeller was interested in this area.

ABDELLAH:

Yes, Mary Rockefeller was very, very supportive of nursing and was very interested in innovative approaches to nursing.

But, DeBakey, himself, was unusual for a man who was a surgeon, a cardiologist to be...but he could see the importance of nursing and working as a team. Those were exciting years and we had a very welcome home as part of the National Institutes.

But you are right, the Eisenhower administration was very supportive of research and those were the times when one could develop it and get it going.

WEEKS:

Statements like this come out of oral history, George was just talking one day...he was talking about Rockefeller, talking about going to him to get support for something and you get these little asides, how this happened...what Bob Taft said, you know he was going to run for president back in those days, the nomination at least, and said "I need a health bill", that's why he supported the Hill-Burton, you know. But when you read the average history book, you don't read that.

ABDELLAH:

So we owe a great debt to that small group - as a part of the National Advisory Council that gave us the encouragement and support and said "Why not."

That spearheaded the first federal commitment to support nursing research and then we got into training grants. We realized the effect of research development grants and we knew that we had to have a parallel training

program, otherwise we'd still have only engineers and social scientists doing research in nursing.

WEEKS:

And this is still ongoing?

ABDELLAH:

Yes, this is still ongoing--the base of operations has moved back and forth, still in the PHS, but it has moved into different agencies, at the moment it is under the Health Resources Administration, and eventually, with the consolidation under the Reagan administration, we might very well see that back in NIH.

Fortunately, research has still a lot of credibility in this administration. It hasn't been easy. The budget for nursing research probably, compared to other support, that for nursing research is not very large. It probably has exceeded more than five or six million per year, which in terms of the billions in other areas is rather small, but it has had a great impact.

WEEKS:

I think that the fact that you have been able to establish this is very important.

ABDELLAH:

Yes, and I do think that it will survive and will continue on, even though at a lesser budget.

We are also trying to encourage nursing research in a variety of the Institutes, for example, in the National Institute on Aging, which Robert Butler heads up. He is very much interested in seeing nurses get involved in nursing research. And there are areas, particularly in relation to the aged

where I feel nursing can make a great contribution.

WEEKS:

I'm in that category now myself. I look around me and I realize we don't have the answers. I feel I have myself, but...

ABDELLAH:

We are getting at more basic answers which is good, more fundamental and a better understanding of different life styles.

WEEKS:

That takes us right up to progressive patient care.

ABDELLAH:

Progressive patient care...one of my favorite subjects.

WEEKS:

I've been wondering, where did this idea develop?

ABDELLAH:

I got interested in it somewhat in my own research and my dissertation. At the time, I was focusing on trying to identify both the overt and covert problems presented by patients and then part of that was to develop a typology, if you will, in terms of classifying them.

So essentially, if one were to think how it did develop, I suppose one would need to go back to Florence Nightingale, because she was the first one to say that you should group the sickest patients near wherever the sister nurse or the charge nurse was, which was your early beginnings of intensive care. It did make good sense. Also, I have always been interested in some form of patient classification, in grouping by common needs.

It made good sense not only in terms of management, but in terms of really focusing on specific patients and their needs. Of course, obviously, in my

own nursing service experience, if you just try to meet the needs of the whole unit, you are not going to get very far.

WEEKS:

Now how did the Manchester Study come about?

ABDELLAH:

After my year at the Western Interstate Commission for Higher Education, Dr. Thompson, was with the Hill-Burton program at the time, Ed Thompson, he worked with Jack Haldeman, who headed up the division of hospitals. Dr. Thompson knew of my interest in research and invited me to head up the research project--well we didn't call it progressive patient care then, but it was an effort there to look at the different ways to organize hospital services and what could be done.

Manchester Hospital was in Manchester, Connecticut. Mr. Thoms who was the hospital administrator then expressed some interest and offered the use of his facilities. We had a small house on the grounds there that we used as a study house. We set up a fifteen member interdisciplinary team. Charlie Flagle was our industrial engineer. We included architects, dietitians, therapists, and nursing and hospital administrators, and manpower type people that really worked with us. So we had an exciting team.

We did a variety of studies there, looking at staffing patterns, looking at the nutritional aspects, looking at the architectural design and the engineering, looking at the whole concept of how it might be done.

I remember taking a whole briefcase of some basic studies we put all together, but how do you put it all together...? I happened to be on an assignment at Case Western Reserve in relation to some mental health conference and I had some time one afternoon that was free. I began looking

at this and somehow it all seemed to fall into place in terms of those patients who needed intensive care, those who needed intermediate and then those with self care.

It was from that that we began to think of a way. We always wanted to show that the care was not static but rather progressive. One would progress from one stage of recovery to the other and I guess that's how progressive became a concept in itself.

Then Dr. Jack Haldeman and the team and I wrote the first manual which we called "The Elements of Progressive Patient Care," and made that available.

Looking back in terms of that whole assessment, there was no difficulty in getting interest in intensive care, in coronary care units, and the spinoffs there, and even intermediate care, but we had great hopes for self care. But it never really came off there, because it was viewed by many as hotel type, motel type care, not requiring professionals.

One of my deepest disappointments was that I always tried to say that self care may indeed require higher levels. It is harder to work with someone in terms of self care, because you are dealing with...in the intensive care you can deal with a specific problem (health problem), even as serious as it is, but in self care, you not only have a health problem but you have this total being, this total person, and helping him or her to make the next step and adjust to that, dealing with many of the behavioral support problems which are much harder to deal with.

We had great difficulty even in the early self care units. We set up to get physicians to visit them. Oh..."They don't need any help...I'm not going to spend my time, you look after them." That was a part of the concept that never really caught on.

WEEKS:

How did you explain or sell this idea to the physicians? Did you have difficulties?

ABDELLAH:

We had no difficulty selling the intensive care, they bought that immediately. In fact the early intensive care units were pretty much limited to coronary care. Since then, they have been broadened to include a variety of patients with different diagnoses. That caught on, they could see that and they liked the support and that was no problem.

The Loeb Center at Montefiore Hospital was a good example of a self care facility. It was a 40 bed unit and although that was established in the late fifties, that has not been replicated in other places. Yet there was very excellent documentation from a cost-savings standpoint to show that you could move a myocardial patient from an acute care, let's say after seven days, they could move to the Loeb Center, spend about three weeks there, it's a lot cheaper, and then provide the transition to the home center.

WEEKS:

Some of the hospitals now are trying to develop intermediate coronary care, something between coronary care and regular, whatever that is.

ABDELLAH:

The encouraging part that has occurred recently, with the rising health care costs, and everyone looking at ways to cutting back on that, the message is finally getting through that if we are going to do something about cutting down on costs, then indeed we have to spend more time on prevention.

This one publication of Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention (1978), which identifies some major

health areas such as long-term illness, that has spurred a lot of interest in terms of prevention. There is a lot more interest now in developing self care units then there was in the late fifties and also linking that with a community setting, a community mental health center or a community health center.

Now some of those programs are, in the Reagan administration, designated for closure, unless, hopefully, communities will pick up these centers, because you can do a lot in terms of prevention or health care with those centers.

I do think they can provide a very significant contribution in the whole prevention area.

WEEKS:

Dr. Haldeman was quite an advocate of the community health center, wasn't he?

ABDELLAH:

Yes, he was, he was one of the first physicians to see the impact of that, that if you had a community health center, if you had a commitment to preventive health services, then you could prevent long-term institutionalization.

Yes, he was a great leader in that, and that was one of his great interests.

WEEKS:

The McPherson experiment took place in '62 and I can remember we made a trip to Manchester. We didn't meet with Mr. Thoms, he was away that day, but we did come to Washington and meet with Dr. Haldeman and I think, Josephine Strachan was there. I can remember she showed us the manuscript of your

report (enormous). Then we did go to St. Paul to see St. John's which was one of the early ones to start.

We came away very enthused and I think it was a good job. We retained the same administrator, Jim Sullivan, kind of an abrasive man, but very forceful in getting things done, which was needed, but then he went on to other jobs and since then the administrators have been less interested. They weren't in on it at the beginning.

I agree with you, out of this has come intensive care and coronary care and burn units and all of these other kinds of specialty units.

Now, can we make a connection between why you had all this interest and were doing all this work and publishing? Then the next thing I knew,...I entered the picture in '62 and by that time Kellogg was supporting the intensive care study at Battle Creek Community Hospital. That, I think, was done by Larry Hill, then later in 1962, for some reason, this money was granted by Kellogg Foundation to do the McPherson Study because, I suppose, it was a small rural hospital.

ABDELLAH:

Yes, because that was one of our concerns. We knew it would work in the big hospital, but would it work in a small one? And because two-thirds of the hospitals, most of them Hill-Burton, were under 100 beds, we really were concerned.

WEEKS:

I think it really did work there and particularly the hospital-based home care, that was outstanding. I took many rides with those nurses and visited patients.

ABDELLAH:

Yes, we'll talk about that in relation to long-term care.

WEEKS:

I've often wondered how Kellogg got interested in this. Had you served on the Kellogg Advisory Committee at this time?

ABDELLAH:

Yes, for seven years. I was on the Kellogg board. It was during this time I got to know Andy. We would chat about it and got people interested in moving ahead, plus, Kellogg has always been very innovative, getting on the cutting edge of support for some of those things. Andy Pattullo was of enormous help. He was also on the Advisory Council with Haldeman's group and then later with the National Center for Health Services Research.

WEEKS:

He has done a lot for the field, there is no question about it.

ABDELLAH:

He was a very strong advocate and we owe him a great deal.

WEEKS:

I like him, he seems to be so relaxed, but he knows everything that is going on, knows everybody.

ABDELLAH:

He is a walking history himself...and George Bugbee.

WEEKS:

And George Bugbee, was he on the advisory board at the same time you were, or before?

ABDELLAH:

Probably before, but I got to know him a little later at the Center.

WEEKS:

Was it during your progressive patient care study that you developed PACE or was that at another period? Do you call it PACE or P.A.C.E.?

ABDELLAH:

We refer to it very often as PACE. It really started then, that was the very early beginning. I guess we spent about twenty-five years developing some form of it. Because progressive patient care certainly was a form of classification. But at that time, we needed a lot more work in relation to definitions and that kind of thing.

In relation to PACE, the group that I worked with that was most instrumental, was headed up by Dr. Paul Densen, at the Harvard Community Health and Charlie Flagle, and Sidney Katz at Michigan, now at Michigan State. Sidney was at the Benjamin Rose Hospital at the time, at Case Western Reserve Long-Term Care Facility. The PACE really got into momentum when we were able to stimulate the project that Densen headed up, which focused on working with some twenty-five hospitals in the New England area, primarily in Boston. They were looking at (these were primarily chronic disease hospitals, so their focus was on the long-term patient). I think the important step forward there was the development of uniform definitions. Which subsequently lead to the Long-Term Care Minimum Data Set (I can give you a copy). We realized that we had to have uniform definitions. If you are going to get into comparative data you have to have uniform definitions and decisions about what kind of data you can collect.

I guess PACE in its different generations has had about a twenty-five year history. Interestingly enough, when the Health Care Financing Administration was established by Secretary Califano in March of 1977, that whole effort in terms of PACE was moved, transferred to HCFA. Although I stayed in the PHS, I

was still consulting and working with them on that. We had called that Patient Appraisal Care Evaluation, which is what PACE stands for.

We couldn't get anywhere for about fifteen months in selling that idea because it was interpreted as more a patient evaluation kind of thing which, in a sense, it was. With that administration, Califano and then stemming into the Reagan administration, with the focus on cost savings, we changed the title to Patient Care Management System. That implies some indication of management, cost saving, so PACE had a change of title with essentially and basically the same approach. It is now referred to as Patient Care Management Systems. I think it's a lesson one learns, don't give up. If you can't move something under one title, change it and change it, but don't lose the concept itself. If it communicates a management, a cost savings, you can succeed in getting it into the system.

That took fifteen months. We thought we really had built that into the new Medicare/Medicaid regulations, to require for all the skilled nursing facilities and intermediate care facilities, that they had to have some form of patient care management system, and that this material was available.

That actually was signed as a last act by Secretary Harris before she left the department. Of course after November 4, 1981, things changed drastically. Then the Reagan administration with its commitment to de-regulate, put a hold on all of those. It was very frustrating. We got the Secretary's signature, and all these years, we wanted to get this into the system and now it's been put on hold because of the present view toward regulation.

WEEKS:

But I think that people who look.....

ABDELLAH:

We were talking about the new regulations in the Reagan administration at the end of the tape.

We did make the material available to the states and I understand that a lot of states are picking this up on their own. Even though it is not mandated in the federal regulations, states now realize the importance and value of patient classification and assessing needs, and they are doing it on their own. Perhaps in the long run, this will have a more lasting impact.

WEEKS:

Are you letting the word "diagnose" come in once in a while?

ABDELLAH:

Oh yes! I remember one of my first books that came out, I used the words "nursing diagnosis," which was heresy. Since that came out in the very early fifties, I've changed my own thinking about nursing diagnoses. My early definition was that nursing diagnosis referred to problems presented by the nurse which the nurse could do something about. Now, twenty years or more later, thirty years really, I realize that nursing diagnoses are really the problems presented by the patient or client that the nurse could do something about.

I think it shows the changing in my own thinking and experience and the state of the art. Because at that time, we could deal more with the process of nursing and nursing care, rather than getting at the assessment of, the impact of, care upon the patient or client. This is where the state of the art is moving a lot closer to getting more sophisticated, as we get more nurses prepared in research.

So one's thinking changes, over the years, too, in terms of what you perceive is critical. But I am pleased that a lot of states have picked up

PACE, as you call it, and decided "Gee, this is worth doing", and they have encouraged facilities in that state.

I must say that Dr. Paul Densen deserves a lot of credit in that he has continued to keep involved in consulting with nursing homes and in training them to use this kind of thing.

One of my things that I am very proud of is that in '74, when Secretary Weinberger, at that time, asked me to head up the Office of Nursing Home Affairs, which was at the Secretary level. The time that we moved into looking at nursing homes, the state of the art was such that we really had no data to really tell us about what was going on in those homes.

At the time there were 16,000 skilled nursing facilities and about 7 to 9,000 intermediate care facilities. I remember visiting some facilities, which were approved by the what was then called the American Nursing Home Association--changed its name to American Health Care Association--which covers pretty much the profit-making nursing homes. I had just visited a facility out in San Diego and it was one of the most discouraging visits because of the lack of attention and real care to the patients, the poor food and the lack of professional health involvement.

I can see even to this day, in the lobby, a big plaque "approved by the American Health Care Association." I had to speak that evening to their executive council. This was my first official speech in that area and I remember I said that the San Diego zoo had provided much more care, better care for their animals, than they did in this nursing home.

Well, I think I needed about two people to protect me leaving that meeting. The next morning, and for two days, Secretary Weinberger got all kinds of demands for my resignation, all kinds of hate mail. I almost had

literally two contracts out on me. I was called in by Secretary Weinberger and I thought, this is it, I get my pink slip for sure, but he had a big smile on his face and he said, "Faye, you must be doing a good job, keep at it".

That was 1974, it took me four years though in working with that Association to turn it around where they volunteered to use PACE and to provide the training and to begin to bring about some changes. I think one of the awards I am most proud of is that American Health Care Association gave me the Better Life Award.

So this was the group four years prior to that opposed me, you see, and then they gave me their highest award, four years later. So that was kind of fun. So we could begin to see some changes, it happens that there are many still that need to be made.

Many of the facilities now are using this patient classification. What it does is it forces the nursing personnel and the physician, hopefully, to go in and really look at that patient, not just a check list kind of thing and really be concerned with the care that is being provided. That led, hopefully, to a lot of reforms in terms of the whole survey process and approach to assessment by both regional offices and state offices and some of what has had some good spinoff.

WEEKS:

It is very necessary, the work you are doing now, when you think of 20 years from now, all the added facilities we are going to have to have. If you can get all these things established now...

ABDELLAH:

Also, we feel that this is where self-care and prevention may come in, that we need to do a lot more in home health and community health and keep

people out of institutions.

WEEKS:

Yes, this is very true.

ABDELLAH:

Our own studies in long term care show that they do much better if we can keep them out.

WEEKS:

My wife and I have a pact, we going to take care of one another as long as possible, and, no matter how hard it is, we are going to keep our home and keep together.

ABDELLAH:

It is so important. Yet, from the federal role, I would hope that we would provide some ways in which it would be possible for people to remain in the home with some support services, home aides, meals on wheels. Also one of the things we got interested in is respite care, so that whoever is taking care can have a rest for a two or three weeks period. Also, I don't know if it will ever get through, family support care. So that one can be given support, additional support, for caring for a spouse at home, or a member of the family.

I think we can learn a lot from countries abroad. They make much greater use of the extended family than we do. One of the things from working with the National Institute on Aging, we do know that 5% of those 65 and over end up in institutions. But what about the other 95% who don't? So Dr. Butler has been very much interested in carrying out long-term epidemiologic studies at the Gerontology Institute, which is in Baltimore, but which is under the National Institute on Aging. So there are some very basic epidemiological

studies that will give us a better picture and understanding about the aging process...the environment in which those, who are able to, function...what keeps the 95% out? Even though they have the same, many multiple problems, what makes it work? So often, as you know, in research we sometimes focus on what doesn't work but we really need to focus also on the success, what does work. I'm sure we'll see a lot more, as we focus on the needs of long-term care, that we can do.

I've been very much involved this year in working with the staff on planning for the White House Conference on Aging, which is in November of 1981.

There will also be a congress, a World Congress on Aging in 1982. That is going to get into a large area in relation to self help and prevention in relation to the elderly. The conference deals with very broad things, not just health, but nutrition, housing, income...So that is going to be a very exciting congress.

WEEKS:

I'm very sorry that Walt McNerney is leaving Blue Cross, because the last time I talked with him he was sort of letting his imagination go and he was talking about the things he thought Blue Cross should and could do and many of them were in regard to the elderly and many of these were support services, many of the things you don't think of as an insurance project.

ABDELLAH:

Well, Blue Cross you know, early on saw the need to support hospice care. That is for the terminally ill. It took us three years within our department to get any interest in hospice care at all. Now there are about twenty-six demonstration projects. But Blue Cross, under Walter's direction, has been very innovative and really out on the cutting edge of things.

WEEKS:

Hopefully, some of these ideas will continue. I don't know what his plans are for the future, but I hope he can stay in the health field because he is very imaginative...

ABDELLAH:

Very much so, specifically on the hospice care...the difficulty we had was in getting any recognition for support for bereavement services. We know from the work that Dr. Cecily Saunders has done at St. Christopher's in London that bereavement services for one year, working with the bereaved, was a very essential part. There are some parallel studies coming out of London now which show that if you don't have bereavement services then in the spouse you see increasing strokes, heart attacks, suicides,...and you can do a lot.

WEEKS:

It is very difficult for a couple who have been together for many years, they depend on each other for a whole life style.

ABDELLAH:

It is absolutely essential.

One of the amusing incidents, somewhat amusing, but frustrating...The reason given why the department could not support bereavement services was that, of course, that program would come under Social Security Administration, and they said, "Well, after the patient dies, that is the end, you see, and the computer can't handle it."

You are right, Walt McNerney was one of our great pioneers.

WEEKS:

Maybe we can talk about hospices some more later. Would you like to say something about your nurse scientist graduate training project?

ABDELLAH:

Yes, I mentioned the importance of having a parallel training program with nursing research because if you can't have prepared nursing researchers then the research is not going to have credibility, and would not be accepted. Certainly the competition with the various NIH councils and the competition for funds...it is a very real problem, very acute today.

We felt that it was important to prepare and begin to open up the doors for the preparation of nurse scientists. One of the great difficulties early on in setting up this program was to get certain departments willing to accept nurses for graduate study. The excuse then was, well they won't stay, they'll get married, we don't want to invest all that money in them. There wasn't as much emphasis then as there is today on the dual career. I think you wouldn't encounter that as much and it is quite common now to have both working, the wife and husband.

We found that the departments of sociology, psychology, and of education were the ones which readily opened their doors. Next to that, I would say, anthropology. But the last of the graduate departments to open their doors were the basic sciences, and then the one that we've had the least success with, economics.

We had to really prove ourselves. We were fortunate in that some of the nurses who were interested in graduate study were willing to be guinea pigs and pioneers. It literally took one or two successes in that university to get a willingness of graduate departments to say, yes, we will be willing to admit some others.

We had some carrots too to offer. We did provide at that time rather generous stipends and all the costs. We did also provide in nurse scientist

training grants some faculty support, and some department support, so that this made it possible at least to establish a credibility within certain universities.

That was very exciting to see that happen. But I must say that a lot of the credit goes to the first enrollees in those programs, because they really sold it.

WEEKS:

They were watched very closely?

ABDELLAH:

Oh my, there was nothing we could do to convince them as much as one good success story. I would say it took about seven years, because those programs at the time were on the average about five years, it took about seven years to begin to see some interest on the part of selection committees, the willingness to accept nurses for graduate study. These were primarily women, but we had some men nurses going on also.

But in economics we tried all kinds of inducements to get nurses interested in health economics. We only had one candidate and then she withdrew for personal reasons after the second year. I feel that's an area in which we should develop a lot more sophistication.

WEEKS:

Where are these people going career-wise?

ABDELLAH:

I did an analysis of all of our fellows, I've forgotten over what period, to try to find out what happens to them. Are they doing research or what happens to them? Interestingly enough, we found that about half were in some phase of research, not necessarily directing research and about half, because

of the clamor and shortage, about half went into deanships, administrators. At first that bothered me a little bit, but when I began to see what they were doing...For example, there was Rozella Schlotfeldt, at Case Western Reserve, who was one of our most dynamic deans there. She created an environment whereby the faculty could do research. In fact, she almost made it a mandate, that in order to move in the system there, you were expected to do research and get involved in research. It was at Case Western Reserve that we set up one of our first nurse scientist training programs.

So I had about half a dozen key nurses, who with their doctorates, were willing to create an environment...and not tell their faculty, well, you don't need any time, you can do that on your lunch hour. Some feel that unless they are doing research, that that support for them is wasted, but I don't think so. They create an environment and you've got to have that, and they have stimulated a lot of others.

WEEKS:

When I was editing Abstracts of Hospital Management Studies, we made a great effort to get nursing research so I was in touch with many of these people. I didn't realize so many of them came out of your program.

ABDELLAH:

Yes, it was very exciting to see what could happen.

But as you look around the country now, a basic requirement for a deanship (it is now, but it wasn't then) is a doctoral degree. Many of them have continued on to create an environment to do research and I know several of them have gone on sabbaticals where they do continue to do research. I do know settings, the University of Pittsburgh is a good example, and Case Western Reserve still, and with Harriet Worley who is at the University of

Missouri, these are places where the faculty are also doing clinical practice. This is where, I think, the best indicator and stimulus for them to get into research are. If they just stay in the classroom or on the academic campus and not really stay with the clinical, I think they are missing an awful lot. That is the thing that is keeping it in that area.

WEEKS:

You must look back at this with a lot of satisfaction.

ABDELLAH:

Satisfaction and some frustrations. I keep thinking, I wish we could do more, and wish we had many more research pockets developing.

We had even at one time envisioned a National Institute on Nursing Research, and yet realizing that nursing is non-categorical. I have come to realize that our best impact in terms of nursing research is to have pockets in each institute--in heart, lung, cancer, neurological, arthritis, metabolic, and mental health.

Nursing, like public health, is really non-categorical and has to cut across several disciplines.

WEEKS:

Going back to progressive patient care, your team approach there certainly worked out well.

ABDELLAH:

Absolutely, there was no way that one person could have dealt with the architecture, the nutrition, the whole plan of a staff and all. So that was a marvelous opportunity for us to build on the engineer's skill, the architect's, to really work together. It was a fun group to work with, too. It is fun to see, too, if you wait long enough, sometimes some part of the

concept will graudally pick up. There is greater interest now in prevention and in home health care.

Still the nurse scientist program is quite active and there are a number of nurses who have gone on for postdoctoral fellowships, although those funds have been cut drastically. There has been some parallel support through the Robert Wood Johnson Foundation and a lot of the nurses who have gone on and done their doctoral are taking one of those fellowships for postdoctoral experience and getting into a variety of areas.

I do feel that the training component is absolutely essential and needs to parallel any research that would go on. I feel that even in these difficult times, even with reduced monies, we can still continue in a small way.

Then we are trying to piggyback on other institutes, get other institutes interested in supporting nursing research. There are areas where I think nursing can make a real contribution. So that is what we are trying to work on now, to get spread out.

WEEKS:

I think you have done a marvelous job.

ABDELLAH:

We have learned a lot and we have had a lot of help.

Now, I don't know whether I mentioned it here or not, one of the things which has stimulated a lot of research is the Academy of Nursing. I was fortunate in being selected as one of the Charter Fellows of the Academy. Some of the early papers which resulted from that were directed toward a much broader effort of health services research and getting into the models of care. That is where the National Center for Health Services Research (NCHSR) helped me a great deal in looking, not at just nursing research, but at health

services research and at deliveries and models. And you know what a great person Paul Sanazaro is, and Evelyn Flook. It was a marvelous opportunity to work with someone like Dr. Sanazaro, who was really so far ahead of his time, when you think that he was the one who first conceived of the first PSROs and the first models in terms of setting up training centers and was very supportive in looking at the broader picture of the health services delivery using the team approach.

So when I got involved in the Academy and eventually became the president of that Academy, it was possible to stimulate among the group an interest in a broader health services delivery research.

WEEKS:

Is there any requirement for fellowship, is there a requirement of research or investigation?

ABDELLAH:

Yes, there are criteria in terms of membership. We spent our first year developing criteria for admission to the Academy. It requires the research undertaken has made a direct change in the trends or thinking, whether it is in education or in clinical practice. But it is not just the research per se, but what impact has this had on changing the system or delivery or service or an educational model. It has to show some impact.

WEEKS:

Has this created much interest as far as people applying for membership?

ABDELLAH:

Oh yes, when we started there were thirty-six charter members and now it is well over 500. And it is just about seven years old. The year 1983 will be our tenth anniversary.

But there is a lot of interest and we are also trying to bring in some of the younger scholars, so that we have a mix of both senior and younger people, both with the clinical background, research and then the educational. So it is a balance, looking at the total picture. It is a very exciting group.

One of our immediate past presidents was Dr. Linda Aiken who is now vice-president of the Robert Wood Johnson Foundation. So we have had people in settings where they could stimulate things. As a part of our work in the Academy, Linda Aiken became very much interested in what we call the teaching nursing home.

Robert Wood Johnson made several grants available to establish teaching nursing homes.

Essentially what this would do is to require the student nurse to have experience in a nursing home as a part of the basic training and the nurse faculty to assume responsibility for the home. Dr. Robert Butler is doing the same thing with the medical schools. You see, very few schools require clinical experience in nursing homes, and that has been one of the reasons why students, whether nursing or medical, don't get exposure to the nursing home. Two-thirds of the staff of a nursing home is made up of nursing aides and orderlies, so you find a very small percentage of professional nurses seeking nursing homes as full-time career.

WEEKS:

It seems in our area that if there is one nurse on a 100 bed, 200 bed facility, the rest are aides, orderlies, etc., and there is little or no coverage.

ABDELLAH:

We feel though that by making it a part of the basic experience...also, the grant builds in a requirement that the nursing service person be involved, there are commitments in there in terms of direct involvement with the patients.

WEEKS:

Because there is an entirely different set of problems, and of course this would help in long-term care in the hospital also.

ABDELLAH:

Yes, it would, because again your assessment tool comes in, if we could use that in terms of...at discharge, make a determination about appropriate placement so that some patients obviously do not belong in a nursing home. We found in our own studies that approximately 20% to 30% were misplaced. If there were support services or day care centers, home health, they could do much better outside the institution.

WEEKS:

Didn't you find in you progressive patient care study that one of the big problems with the long-term care was what to do with the patient, how to get a place to release the patient to?

ABDELLAH:

Exactly, that still is a problem. You have got to have that community support system. Without that you can't really move them out into the community. Now some states, such as Massachusetts, have pioneered in this area.

In their budget for long-term care for the first time they budgeted a sizable amount for the development of community support services. I think when we can get states to do that so they don't put all their money into institutional care, and say look we've got to provide the support services.

We can't move these people out unless we have the support services. So that is one of the breakthroughs. If we can get more states to do that.

WEEKS:

I must interject and tell you one of my favorite nursing homes is in Kalamazoo, Michigan...the Upjohn family must have endowed it. We have an aged relative there, 94 years old and she is alert. We see her about once a month and go out of there saying "Isn't this the marvelous place." We have been in many of them, my parents were in one, so we've seen a good many of them. I looked all over Detroit before I put my parents in one; they had to both be in one. But when I see this place which is kind and clean and odorless and immaculately run, with a heart, I wish they could all be that way.

ABDELLAH:

One of the benefits of working in the PHS is that many of our leaders go into the private sector and we have the opportunity to continue to work with them. Dr. Ted Cooper is now the Vice President at Upjohn for medical research. He was our Assistant Secretary for Health, one of our very dynamic leaders. By the way, he is on the national advisory council for the White House Conference on Aging, so you see what an impact that is going to have. He can recognize this nursing home in Kalamazoo. Upjohn has done a great deal...and with his broad perspective and leadership, that will be important. I'm sure we'll see a lot more innovative things that he is willing to participate in.

To show you an example, we could not get any support to develop a mini-conference report on nursing for the White House Conference on Aging. It was inappropriate for PHS to support the conference, a federally supported conference. Well, Dr. Ted Cooper came through and supported a mini-conference

where a position paper could be developed, where nursing leaders in gerontology could have some input. This has become a part of the official document for the delegates. We are very grateful to Dr. Cooper.

WEEKS:

In fact, Kalamazoo was one of the first cities in Michigan that had meals on wheels.

ABDELLAH:

That is right and of course Battle Creek with the Kellogg Foundation has done an enormous amount in health. We have worked very closely with Barbara Lee. It is a marvelous example to show what a foundation can do in cooperation with the federal government, working as partners.

WEEKS:

They have been very, very good.

ABDELLAH:

The Robert Wood Johnson Foundation now is providing other areas of support, but I am very excited about this teaching nursing home. I do feel that it could really turn things around. Because once a nurse gets interested in nursing homes and if they are exposed to the Kalamazoo type facility and see what is possible, I think we could get a lot of our young people working in that setting.

WEEKS:

I think it is a marvelous idea. Don't you think this might also put some force to the others to improve, which is needed badly?

ABDELLAH:

Yes, especially, it is particularly important now. I would be the first to say that in the federal government we have been over-regulated, but some regulations are good. Such as classification standard. I believe a lot of

the associations and states are realizing that not all of it is bad and certainly the taxpayer has to ask for and receive an accountability of funds. In order to get accountability you have to have at least some monitoring and surveillance functions.

WEEKS:

Our whole social program, it seems to me, is based on rather faulty foundations, because, I think in the first place, we should sit down and say what do we need, what needs to be done and when we decide what needs to be done, then find the money to do it, rather than keep spending the money without knowing the reason for it.

I think most any sensible person knows there are social ills that need to be corrected and we should correct them but we need to find the way to correct them.

ABDELLAH:

It's an interesting challenge during this administration, with the retrenching and tightening up. It's not all bad, I think a lot of it will be helpful for us in the long run. It will help us to really order our priorities, and force us to say, well, with the limited budget, what will have the greatest impact in terms of helping people?

WEEKS:

Most people as individuals know they have to live within their income level and they should expect the government to do the same. So maybe we have to go through the painful period before we appreciate that.

Should we talk about the extended role of nurses now or later?

ABDELLAH:

Fine, I think that fits in quite well.

WEEKS:

I had a feeling that the poor nurse doesn't really know what her role is. I'm assuming a nurse out in practice now. I think that she wants to be a professional, which she is, but she wants to be considered as such. In fact, we had our strike at the University Hospital in Ann Arbor, not so long ago and I think basically, that's all it was.

ABDELLAH:

That's right. It was not necessarily the salary, but the feeling about the decision making and the involvement and the comprehensive care and the quality of care.

It has a real tie in with progressive patient care, the extended role. In fact, our early thinking in relation to that, we realized that as nurses became prepared in intensive care, or coronary care, that was a special additional skill that they needed. The early work of Dr. Loretta Ford at the University of Colorado and Dr. Henry Silver defined what started out to be the pediatric nurse practitioner. It was the first early model, the nurse midwife, of course, with the Frontier Nursing, going back some sixty years now, was the first role model in nurse midwifery. So those were the two early ones.

The others in terms of geriatric nursing and some of the other specialty areas came along later. In 1970, we were very fortunate at the time to have Dr. Roger O. Egeberg, as our Assistant Secretary for Health and Scientific Affairs. A very forceful, dynamic individual. He was willing to head up a task force and one on which, with his help, we had key people from AMA, AHA, the different nursing organizations, people like Dr. Ed Pellegrino, past president of Catholic University of America. From that we were able to put

together a document called Extending the Scope of Nursing Practice. This was published in November 1971, which for the first time spelled out the specific areas of function for the extended role of the nurse. We defined primary care, acute care and long-term care, and that has had some impact. Following 1971, there were about thirty schools which became interested in setting up the expanded role for the nurse practitoner and primary care nursing.

The federal government did support, through our National Center for Health Services Research (NCHSR) six demonstrations which were called Primex projects, essentially nurses providing primary care. At the time, we had to establish it as an add on, a year added on to the regular nursing, with the hope that in time, this would become a part of the basic curriculum. I think in many instances it has. In some instances it has gone on and developed into a master's program. Looking back, I would perhaps change the "extended" role to "expanded" role which is more realistic.

Some criticism directed at the nurse practitioner in the early programs was why we always had a physician preceptor. The functions that they were picking up were the assessment skills, patient assessment skills. At the time many of those skills were in the domain of the physician who had the training.

Doris Schwartz, formerly at New York-Cornell, was one of our primary leaders in setting up the Primex project at New York-Cornell, became our first nurse preceptor to train nurses with assessment skills.

I tried to explain it on the basis that it is an evolutionary process, that until you have nurses prepared in assessment skills who can train others you have to start with the discipline which has the skills. The intent was never to make these nurses pseudo-physicians or second class physicians but rather to use these assessment skills to develop more expertise in nursing

diagnosis, identifying nursing problems that the patient presented, rather than as an adjunct to the physician.

Barbara Bates at the University of Rochester, a physician herself, interestingly enough was able to explain and identify the overlap of nursing and MD functions. There is a small area of overlap, there is no question about that, but there is an expanded role for nursing which does not overlap in the physician area. One can see this now identifying a lot more clearly than in the early seventies, as nurses developed specific areas of competence in gerontology and primary care.

There has been some good analysis in terms of what the nurse's functions are in primary care, and secondary care and tertiary care. Actually, if you look at the whole spectrum of care, the nurse can have a very important part to play in primary care and certainly in long-term care, prevention, and rehabilitation. Where the nurse does not have the expertise as clearly is in the surgical area, requiring the very special skills of the surgeon or the physician. It is a concept that has raised a lot of controversy, but I think it has generated good discussion.

Where it is running into real confrontation now, is that there was a study done by our DHHS that reviewed graduate medical education which predicted a surplus of physicians by 1985 and 1990 and then the AMA became quite concerned about the overload of physicians and concerned about the broadening role of the nurse practitioner. Some states like Texas have been very strict and very rigid in terms of how much the nurse practitioner can do. In that state, the medical society has put quite a bit of restriction on the role of the nurse practitoner. And the concern there is with surplus of physicians and of what is really the future role of the nurse practitioner.

We do feel that from the nursing standpoint, that the expanded role, as it expands into specific areas of content, is not taking over what the physician is doing, but hopefully will provide a team relationship that could be very essential.

WEEKS:

Now how would you define a nurse practitioner? How would you describe the work she would do and her relationship to the physician, the hospital, the home?

ABDELLAH:

The nurse practitioner--the main important function is that she has responsibility for that whole patient or in some instances, the family, so that when she uses her assessment skills, she is looking at that total person's physical, and behavioral needs.

Although her specialty could be in cardiology or in pediatrics or gerontology, she uses those skills in the broadest sense, looking at the total needs of that patient or infant, then working through the whole plan of care.

The heart of it, again, comes back to patient classification. The heart of it builds in the total plan of care. Whereas the surgeon may come in and out and complete that particular skill or specialty, or the internal medicine person, she, as a practitoner, needs to be involved in the prevention, which is a much more appropriate role, an important role for nursing.

The nurse has time to spend with that patient or family in the prevention area, in immunization, and in teaching, and then following on through. If it's in nurse midwifery, again it's working with the good example of some of the birthing clinics that are developing, where she has the total responsibility early on, prenatal, during delivery, and postnatal. It doesn't

mean that she doesn't work with the physician, they work in a colleagueship relationship.

WEEKS:

Now I assume, from what you have said, that in many cases the nurse would be calling in the home, such as a home care nurse.

ABDELLAH:

Yes, home or a rural area or in urban ghetto.

WEEKS:

I think the point you are making is very important in my thinking and that is that the nurse is getting into the home and she is seeing the conditions, the kind of nutrition, or lack of--the total environment, and she has a much better understanding. I think this is one of the things that physicians have lost in that they don't make home calls any more. They don't see the surroundings in which these people live or the conditions or the family or the family problems. So I think that is marvelous.

Now the nurse practitioner, she could work in many ways, she could work as an independent practitioner?

ABDELLAH:

Yes, she can, but I do not see that happening. There will be a few such as Lucille Kinline, who works as an independent practitioner in the area of cardiovascular nursing. Now, we probably have two or three who work in the area of alcoholism, as independent practitioners, but this is not the trend.

The trend is much toward a team effort and we have examples in the PHS National Health Service Corps, where we have physicians, dentists, nurses going out working in underserved communities where there has never been a physician or dentist. They work in that community. Then after two years, if

the community can afford it--it picks up the support of these people and they stay there in the community.

I do think our role in terms of nurse practitoner will not move up in the independent area, but will be more of the team approach.

WEEKS:

Probably in some social agency or something.

ABDELLAH:

Yes, the health maintenance organization, the community health centers, working in ambulatory care clinics, in home health settings, and that sort.

It does not mean that the physician physically is there, but the nurse would have a linkage and some communication to the physician.

WEEKS:

Possibly keep a medical record, a record of some sort that would be available at some central spot for the physician?

ABDELLAH:

Yes, this is where Dr. Sanazaro pioneered. A lot of his ideas such as using the technology and communications in remote areas where a doctor could be two hundred miles away, where you could use technical assistance or a computer and telephone where you could share knowledge using the technical assists.

WEEKS:

You did mention Robert Wood Johnson Foundation...I think they supported a project at Muskegee, didn't they?

ABDELLAH:

Yes, they did.

WEEKS:

How did that work out?

ABDELLAH:

As I understand it, the nurses were to visit the homes as necessary and act as the primary contact.

Yes, that had great potential, that was very exciting. That worked out very well. That's what we need to encourage.

WEEKS:

This is sort of like the frontier nurse.

ABDELLAH:

We can learn a lot from the frontier nurses of more than sixty years ago, although those nurses were all trained as nurse midwives, they didn't limit their skills to just the nurse midwifery, but when they got up in those hills they dealt with the whole family, the father and the children...they dealt with multiple health problems. That was really our first family nurse practitioner in this country.

WEEKS:

Psychologically, it could be good for those people to have the nurse come. If you don't mind my being personal, my mother, when she was living, the last few years of her life had to have a visiting nurse come once a week to give her B12 injections or something. This was a big day for her, she was sure that my father had his necktie on and she was sure that the house was cleaned up and she was sure that everything was in place. Then when the nurse came, my mother would talk with her, ask her about her family in the few minutes she was there.

It did her more good than the B12, I think.

ABDELLAH:

Sure, to have someone visit and be concerned. I think that is actually very important to see that happening. The Health Care Financing Administration did approve a regulation for a direct reimbursement of the nurse midwife. This is a milestone breakthrough, it's one of the issues, direct reimbursement of nurse practitioners, that need to be resolved.

WEEKS:

Well, you have a nurse at the head of that...

ABDELLAH:

That's right, Dr. Carolyne Davis, did you know her at Michigan at all?

WEEKS:

I met her, I didn't know her well.

ABDELLAH:

A very fine person.

We could use the direct reimbursement of nurse midwives now as a precedent. (It does create problems in terms of the projected surplus of physicians.) That may stimulate more independent nurse practitioners, I don't know.

I am inclined to think not, that we still will continue to be as a member of the health team even though the direct reimbursement can be made to the nurse, rather than going through the clinic setup. I think that is very important. It does mean that direct reimbursement carries with it responsibility for accountability for the delivery of that practice. I think that is very important that as practitioners we accept the responsibility and accountability for our practice.

WEEKS:

I would like to talk about education before we are through, but maybe it would be better to talk about the education of these specially trained people at the time we talk about education in general, do you think?

ABDELLAH:

All right, you mean like the practitioner type?

WEEKS:

The practitioner, the ICU nurse, the surgical nurse, clinical specialists...

ABDELLAH:

All right. This is the publication back in 1971 that I mentioned. As I said, instead of calling it "Extending the Scope of Nursing Practice", it is extending and expanding the scope. You see the definitions in here of primary care and then for long-term care and acute care.

Now the specialty training of gerontology, the early developers of guidelines along that line used long-term care as the basis for setting the scope of practice, the parameters of practice, in relation to long-term care. You see a great deal of emphasis on the primary care, on prevention, health surveillance, early detection and that kind of thing.

Nation-wide there is an association called Critical Care Nurses, and that has been a spinoff of a group of nurses essentially who have this expanded role. A variety of pediatric nurse practitioners, nurse midwives, intensive care, coronary care nurses and geriatric nurses, some public health, psychiatric--where they do have a defined clinical specialty, have come together looking at some of their common problems.

WEEKS:

Should these nurses be trained in graduate education, or in a special

course, or how?

ABDELLAH:

That's a very good question. Following this publication in 1971, most of the training had to be established with a one year add on, because basic curriculum did not have a defined area of content in these areas but just perhaps some beginning levels of public health or psychiatry, but not in depth, and certainly no inclusion of assessment skills, or patient care diagnosis.

So that ten month program was with a preceptor and, as I mentioned, most of the first preceptors were physicians, but this has changed now so that many more nurses are preceptors. Our intent was that in time, skills such as the assessment skills, should be built into the basic curriculum. It would be pretty hard to find an accredited baccalaureate program that didn't have some assessment skills built into it. That would be the beginning level. Now we feel that the graduate with a baccalaureate does have the first level expertise. However, those who really want to spend much more depth at a specialty level in all of these areas should go on for a master's degree.

WEEKS:

In the master's degree, this can be pretty well covered, you think?

ABDELLAH:

Yes, in terms of what might be a clinical nurse specialist.

WEEKS:

What about all these thousands of hospitals we were talking about under a hundred beds? Kellogg supported the coronary care unit study up in Standish, Michigan in a little hospital a while ago and I guess have supported many others since, so that the small hospitals are attempting to have intensive

care units and coronary care units, particularly.

Most of the people, how are they trained? How can we train them in the future? Maybe this would be a better way of saying it. Could there be regional short programs? What could be done?

ABDELLAH:

The most common approach to prepare the coronary care nurse is a six weeks training program in intensive care and coronary care. But this would be provided through continuing education programs and a number of those are supported throughout the country.

Some states now require nurses to have so many continuing education units. There are a number of accredited programs now that are put on by universities, short-term training, but it is limited.

We do feel, though, that if one works in an intensive care unit now, especially where you find all kinds of patients that you do need a longer period of training. I think we have to look at different approaches, short-term as well as long-term training and not neglect either one.

WEEKS:

I was going to ask you what do you see as the future of nursing education, considering the two, three, and four year programs plus the graduate programs.

One, is there a feeling of difference among nurses as to their training? Is this likely to impinge on their relationships, whether they've had a two year, or three year or four year training?

ABDELLAH:

Yes, you have really hit on a sensitive area, in that this is one of our dilemmas in nursing. Interestingly enough, it was Mary Rockefeller who provided the financial support for the development of the model for the two

year program. It was never the intent of that program to continue on beyond just a terminal type degree. But it has in many instances served as a career ladder.

WEEKS:

Is there actually a ladder there?

ABDELLAH:

In many instances, many facilities do provide a ladder where you can spend two years and then you can spend another two years and get your baccalaureate degree. That was not the original intent of the program, which was intended as a terminal degree.

It has been used pretty much as a stepping stone. We know from our own experience, in our Public Health Service facilities, where we do employ some two year graduates, they have to have almost an additional year of clinical practice, an internship, if you will, before one can feel comfortable in giving them any assignment of major responsibility.

There have been many efforts, as recent as our last American Nursing Association convention to try to require the baccalaureate degree as the entry level degree. Students are the ones who are demanding this. They are demanding that professional nursing make a decision to require baccalaureate as the entry level. There was a lot of talk last year about making 1985 the target date, grandfathering some. This has a long history going back to 1923, and the Goldmark Report, when this was first proposed. Undoubtedly, our dilemma of the two, three, four year program is one in which the profession has faced many, many difficulties. The state board examination is the same for all three programs.

I, some years ago, was involved, working with the National League for

Nursing, in getting them to use situation tests rather than relying totally on factual recall trying to get at some measures of judgment, decision making. I hope there will be some major changes in the type of testing that is being developed. There are some encouraging steps in that direction.

We will have to face the day, undoubtedly, that we would be a much stronger profession, in many ways, if we had one type of training program as medicine and dentistry, with baccalaureate as the entry level.

WEEKS:

Are there many three year schools left?

ABDELLAH:

Yes, most of the schools are three year schools. Of about 1,500 schools, only about 300 of those are baccalaureate. so you see, most of them are still diploma.

I can speak with great feeling on this. I am a diploma graduate myself, but then I had to go on the long way, the hard way afterwards to get to the university. I do feel that it will come and the students, as I said, the young graduates are demanding this. They see the opportunities, now particularly for women entering in pharmacy and engineering and medicine. There are many more opportunities for upper class students in high school who can now find entry into some of these other schools, which twenty-five years ago wasn't possible. It was either nursing or teaching.

WEEKS:

This is a question that has occurred to me many times, what kind of woman or man, of course, chooses to go into nursing? How do you as a faculty member screen prospective students? This is a question I faced when I was at Michigan. I used to interview many of the hospital administration applicants,

and I still don't think we knew how to choose the best prospects.

ABDELLAH:

Certainly, you have to go beyond the high academic performance. There is motivation and the commitment, and it is not always easy to detect that.

WEEKS:

Because those who are experienced at being interviewed come in with the story that they want to do something for their fellow man. They have it down pat and you don't know whether there is true feeling or whether it is just something that they have assumed.

Well, I won't ask you that question then, because I think it is a very difficult thing to screen candidates.

ABDELLAH:

It is a very difficult one, I do feel though that if a young woman or young man has had some exposure, like some of the nursing students served as candy stripers during high school where they have some identity with the hospital setting, it gives them a better understanding of whether nursing is a proper career choice. I do feel that the high school counselors, and I am not being critical, but I do feel that we could do a much better job from the nursing standpoint in orienting high school counselors and making current materials available to them so that they can give multiple choices to young people.

The high school counselors' vision of nursing is pretty antiquated today. They wouldn't know what a nurse practitioner does.

WEEKS:

Then let us say, what doesn't a nurse like about nursing, why does she quit? Is it the hours, they are bad sometimes? Is it the pay? Is it the way

she is treated by physicians? Are there more women leaving nursing than there are from other professions or careers?

ABDELLAH:

It is certainly very high in nursing, the turnover is very high particularly for the first two years. Although, unlike some other professions, a nurse can always come back. You see a great deal of in and out, whereas that is not true, necessarily, of engineers, or pharmacists, or lawyers. But nurses, with some upgrading of skills, can always come back.

You find many nurses in the 60s and early 70s still practicing. There have been some very perceptive studies recently about why nurses leave the profession. One that was done at the University of Texas by Dr. Mabel Wandelt was a very excellent study which showed some of the basic reasons why nurses leave, not necessarily the money but the feeling of frustration, the feeling that they can never really complete a task nor that they have total control of the patient care environment. They are not involved in the decision-making process. They need more involvement in some of the policies which are dictated, more freedom in scheduling. I think we can provide much more flexibility in scheduling. but it all comes down to this frustration because they can't see the quality of care being provided that we preach in the classroom. And again this accountability and the autonomy and the partnership in the decision-making process. This is what is so frustrating.

WEEKS:

I think there is another competition that is creeping in and that is that more and more women are going into medicine. The last figures I saw, particularly on the new medical schools, the community hospital based medical schools, with some of them it is nearly 50% women.

ABDELLAH:

That is also true in the school of pharmacy, and engineering and law. This has not always been true, these schools have not always been open to women. This is where I do think the ERA movement has helped us in opening up, making admission groups and committees more aware of the need for balancing. So that is encouraging, but it also means that for the first time, we have had a drop in admissions to nursing schools.

It used to be that we could always pick up the 3.0 point average student, without any difficult. But those top students are now going to the other schools where there are other opportunities, and for the first time we are seeing a drop in admissions to nursing schools. This is of great concern in view of the national shortage that there is in nursing.

WEEKS:

How about recruiting men?

ABDELLAH:

There was an article in the last Sunday's paper, the Washington Post, the private sector is up to about 4.1% now, which has increased. For a long time, it was 2%, very slowly. Interestingly enough, in the federal sector, that is Army, Navy, Air Force, Veterans Administration, Public Health Service, we average about 27% male nurses as compared to about 4% in the private sector.

We have a number of men, and a lot of them go into administration, and a lot of them see nursing, unfortunately, in a lot of ways as a stepping stone, rather than a long time career in nursing. Men tend to turn much more to the managerial positions in nursing.

WEEKS:

That same group that you would be recruiting from, some of them are going

into physician assistant programs, too, aren't they?

ABDELLAH:

Yes, and those coming out, service corpsmen, etc., ironically trained by nurses and they become physician assistants.

We would like to see many more men in nursing. I think there are real opportunities there. One of the problems, of course, is the title "nurse" which has such a feminine connotation. Although there have been many attempts to change that, that has never been achieved.

WEEKS:

Well, it is like trying to find a pronoun that would relieve us of saying he/she every time.

ABDELLAH:

Yes, and like doctor could be either one, but since nursing is made up primarily of women, and with only 4% of men in the private sector, it is much harder, but in time we might come up with something that might be appropriate.

This has always puzzled people, why in the federal services, we do a better job in recruiting men. I do think in the federal system the managerial posts are much more attractive and advancement is much more rapid, than in the private sector.

WEEKS:

I was going to ask you about the National Health Services Corps. The NHSC as I understand it would offer some inducement for men to come into the nursing end of it. For the record, what is the National Health Services Corps?

ABDELLAH:

The National Health Service Corps: its purpose was to recruit physicians, dentists, and nurses to serve in areas where there were nurses probably, but

no physicians or dentists.

About 2,000 counties in the U.S. have no physician at all, and the likelihood of many counties, particularly in Appalachia, some of the underserved areas, even the ghetto areas, the likelihood of having physicians and/or dentists, it is pretty difficult. So this was the whole purpose of the Congress was to provide teams of health professionals to go out into the community. The original intent was that they serve two years under federal support and then the community would pick them up--which means that there had to be a local governing council and acceptance by that community before a team was ever sent out.

The National Health Services Corps provides many exciting success stories. The nurses have done a better job of remaining in the community, but with the physicians and dentists, the turnover has been much greater. Even though the community might be willing to support them, they don't find the scientific, professional stimulation in a small community. They tend to want to migrate back to the big centers. Although, as I say, we can sight several success stories, where it has worked quite effectively, overall, in some of the communities, Appalachia, even Harlem or some of the Los Angeles ghetto where there will not be local support and there will have to be continuation of at least some federal support to maintain that presence.

WEEKS:

Have they come through an educational program supported by the federal government before they go out?

ABDELLAH:

Not all. In other words, you can come into that already prepared, as a physician, dentist or nurse, or you can come in with a scholarship. There is

a payback, for whatever time you have trained.

WEEKS:

I think we sometimes forget how much the federal government supports our health professions through schools. I know our students sometimes assume that they are paying their way, when actually there is a lot of support there.

ABDELLAH:

There has to be, with the cost of it. So that has been a very good way. I think it contributes a great deal. If anything, it makes communities aware of some of their health needs, of the kinds and types of community clinics which should be available, free clinics, and the kinds of services which should be available across the board, that we really haven't paid attention to.

WEEKS:

It is surprising what causes a person to locate in a certain place. I helped, when we were doing the progressive patient care study, I helped try to recruit some physicians for the area. We discovered very rapidly that the things that appeal to them...if you could tell them "this is a great recreational area", you are only 30 minutes from Ann Arbor and the cultural things there, you are only 30 minutes from East Lansing and so on, you are not too far from Detroit, by the way.

Because the young doctors who came in would say "Well, my wife is a big city girl and she would feel lost here, what will she do for shopping in this small community?" Then we would tell them where she could go, so these were the things that were interesting to them.

ABDELLAH:

Absolutely important. It is interesting that you raise that. In the analysis that they did in the NHSC they found that the attitude in the

community, the availability of housing, how far would it be to an educational meeting or getting some CE credits--those were very important factors. You are absolutely right.

Parallel to that you see, we have a number of National Health Services Corps in the Indian tribal areas and Alaska, where you have very remote sites and that is a very important problem. You are absolutely right, you have to look at the total community, cultural needs, how important the medicine man is...you just don't ignore the medicine man and certain traditions in that community.

This is why we have great success with nurses going on with their Ph.Ds in anthropology. Where they have done exceptionally well in understanding and moving into different cultures, particularly the American Indians. With their anthropological training they are much more aware of the importance of tradition and environment and cultures, and how this plays a part in the health practices. If you are selling or approaching any health prevention problem, to ignore all of that courts disaster. In terms of the nurse scientists, which we mentioned earlier, the nurse anthropologists have made quite a unique impact and inroads in working with different cultures.

WEEKS:

That must be very important, particularly in the government services.

ABDELLAH:

Yes, and before all the problems in Iran, we used to have a number of nurse anthropologists in Iran, of all places, doing their graduate work there. Some of them have gone into the African countries and succeeded very well.

Being a nurse first, they use their nursing as an entree and then can

obtain information, where as coming in as an anthropology student one would find it difficult to gain the confidence of the people. Very often they were the envy of other students in anthropology. They used their nursing role to build the confidence of the family or tribe.

WEEKS:

Yes, because this is a very basic human relationship--caring for the sick and family. That is a common language.

ABDELLAH:

Exactly, and hopefully you can see some positive results, and the nurse is able to help them.

WEEKS:

Do you think there is a trend toward physicians beginning to accept nurses as professional colleagues?

ABDELLAH:

Certainly, as individuals, there is no question. One could cite many, many physicians who are our strongest allies and supporters.

In terms of reality though, there is still quite a bit of opposition from the American Medical Association because some physicians feel, from an economic standpoint, particularly with direct reimbursement of nurses, with the surplus of physicians, there is real concern, a feeling that maybe we don't need all those nurse practitioners out there.

What will happen, if there is a D day, a surplus of surgeons, a surplus of obstetricians? It is a very serious problem. We know that 86% of the deliveries are normal deliveries and the trained nurse midwife can handle those and she can have access to the trained obstetrician.

Just in the last year and a half, with this published information about

the surplus of obstetricians and surgeons, hospitals in the New York area and some other states are closing the in-hospital privileges to the nurse midwife, and restricting them to home care or birthing centers. Prior to this year and a half ago, many hospitals were opening up hospital privileges to the nurse midwives and getting a lot of pressure from AMA and from obstetricians themselves not to provide these privileges.

There is all the more reason why the two disciplines need to work together in colleagual relationships. Certainly in looking at this report on extending the scope of nursing practice, the physicians were our greatest allies, a tremendous support as individuals.

I do feel that the nursing profession has a responsibility to define its scope of practice and to get that clearly put into nurse practice acts. I think that would reduce a lot of the concern about nurses taking over. Because if you really define the expanded role of nursing, it is not medical practice. The skills, there are certain assessment skills, indeed, that we do pick up that the physician also uses, but not necessarily for the same purpose. Those skills are essential. I do feel that as we now begin to define specific areas of expertise, in cancer nursing, geriatrics, psychology, that we can begin to get a clear picture.

You are absolutely right, in raising our concern. Many today are concerned about the future role of the nurse practitioner. Whether or not this role will survive with the surplus of physicians, is a real question.

WEEKS:

They feel threatened...

ABDELLAH:

And you see, the nurse midwife is the one who will initially feel this,

because this is such a clear cut thing, because there is a surplus of obstetricians, and the nurses have documented that they can deliver a mother much more cheaply, and provide a high quality of care. The Federal Trade Commission, interestingly enough, has gotten into this and has challenged the AMA, because they feel that the nurse has a right to provide a quality of care at a cheaper rate.

There was a state supreme court case (an antitrust suit) in the state of Virginia regarding a clinical psychologist in relation to direct reimbursement, which supported the clinical psychologist for direct reimbursement, and ruled he was entitled to this. So I think we will need more state decisions in court cases. I am sure this will come to a head.

But what I have been trying to get my nurse colleagues to do is to have states adopt a very strong nurse practice act, establishing the legal part of it clearly, and we have gotten into that a little bit in this report. I think this should help move things.

WEEKS:

In the meantime, you have to move to a minimum of a bachelor's degree too.

ABDELLAH:

There is no question about that, but like in all areas, sometimes our nurses are our worst enemies, because I think they are concerned about their own futures. That is why, as we move to an all baccalaureate, we need to be apprised and concerned for those many thousands of diploma nurses who are so capable, who are doing a good job--so that we can give them some recognition--so they can see their role, and be given the opportunity to obtain a bachelor's degree.

WEEKS:

You would have to absorb them.

ABDELLAH:

Yes, absorb them through continuing education, through some grandfather clause or whatever. There is no way that we could ignore them, because they are an absolutely essential part of practice. I think if they could feel and realize that indeed they would be part of it, they would have less concern.

Interestingly enough, our greatest opponent is the American Hospital Association. The reason there is that they are looking at the supply of nurses. As long as 70% of your supply comes from hospital diploma schools you are going to be concerned.

WEEKS:

The other day I read a statement that said that LPNs, licensed practical nurses, are really a product of World War II. There was such a shortage of nurses that training programs were started, some of them quite informal. Later they got into the one year licensed practical nurse program. What is their value in the future, do you think?

ABDELLAH:

You are absolutely right that they did start during World War II. That was when so many nurses were pulled off into the service or working at other things. There is no question that they have served an enormous role. The Kellogg Foundation was the supporter of the early LPN programs and before they became a part of the vocational education system. So Kellogg supported a good many of those. Like most things that are good, they lived beyond their time, or were absorbed into the system. I think that is what happened to the LPN. At the time the older nurse, 40+, was recruited into that. The present thinking is that if we are successful in getting the baccalaureate degree as a

minimum entry, then there should be a merger between the LPN and the associate degree program, or possibly the diploma degree in some way. That one year of training, twelve months training--there is some good clinical experience there, but there is no scientific basis.

To be quite frank with you though, if the baccalaureate degree becomes the minimum entry, then the merger and compression into the two year, the LPN would become an obsolete program.

There would certainly have to be a group whether we call them LPNs or community health workers--there would have to be some who are lesser prepared. I don't think the health system could finance a total baccalaureate nurse supply. We now have a little over a million active RNs. That would be perhaps close to 800,000 who are in the diploma category. So there is an awful lot of catchup. Our big job now is to really bite the bullet and say that this is important for professional nursing and then set a target date. I don't care whether it is five or ten years. I feel that we should come to a decision and recognize that, accept the target date, and then work with all these groups who are making an enormous contribution. We could not function in the health field today without LPNs, without diploma nurses. The associate degree nurses raise some serious questions because they do have to have an additional year before they can really function in a clinical setting. A lot of programs which are now moving towards the all-RN and cutting back on the LPN programs with the feeling that it costs between 12 and 14 thousand dollars a year for orientation for LPNs and ADs into a system. The feeling is that you can save money and you can provide a higher level of care if you do have an all-RN staff. That was one of the unique things about the Loeb Center I mentioned at Montefiore in New York. They maintained an all-RN staff where

they could provide direct patient care. You do not have all the repetitive orientation.

Interestingly, the VA, which is one of the largest employers of LPNs, has cut back drastically on LPNs. In 171 VA hospitals they are trying to employ all RNs now.

That is a point I want to tell you about our Federal Nursing Council and how that reaches out to the different services.

The future of the LPN is still in vocational training. I think most young people are much more savvy now and move into the AD, at least get an Associates Art degree. Many of those are going on for their baccalaureate degree. You know, originally the associate degree was intended to be a terminal degree rather than a ladder into a baccalaureate degree.

In our own hospital system we employ very few LPNs. We feel we can do a better job working toward an all-RN staff. A few of our hospitals have a 90% all-RN staff. It gives you much more flexibility in staffing and getting involved in total patient care.

WEEKS:

Many hospitals, I believe have hired LPNs or started schools for LPNs merely because of labor shortage.

ABDELLAH:

Labor shortage, yes. That's what forced us into it. History teaches us so much. Post-World War II we should have done something about the LPN, either terminated it or developed it into a stronger career ladder. I believe the state of California has done something along that line where they have an opportunity to go on and not stay at that level.

WEEKS:

This is a problem we faced in Michigan. I sat on the board of an LPN school. We were trying to establish a ladder but it just didn't work out.

ABDELLAH:

Michigan, you are right. In Michigan when I did a state survey with the Cunningham Drug Foundation, there was support of the LPN programs there. I think one of the early famous programs was the Shapiro School for Practical Nurses.

WEEKS:

Mr. Shapiro was president of the Cunningham Drug Company.

ABDELLAH:

Mr. Shapiro was head of the company, wasn't he? It was interesting that I got into that. Also there was quite a bit of Kellogg and other foundation support. Certainly it met a real need.

WEEKS:

Many of the outlying hospitals would have been without help. Even the University of Michigan had to hire some because they couldn't get enough registered nurses.

Another force that I see, maybe I am overestimating, is what I call the paraprofessionals are coming in, the therapists. As an example, last week I visited...

ABDELLAH:

Clinical pharmacists.

WEEKS:

Yes. Aren't some of these people doing some of the things the nurse used to do?

ABDELLAH:

Absolutely.

WEEKS:

And maybe could do as well?

ABDELLAH:

No question about it. Clinical pharmacists as an example.

WEEKS:

As an example, I visited a cardiac patient last week in Ed Connors hospital. The therapists would come in two or three times a day, he told me, to tell him whether he could dangle or whether he could walk across the room. It seems to me that if the nurse diagnosed the care needed she, with the permission of her physician, might be able to use her judgment on that, as much as a therapist. I realize this is only a very small portion of...

ABDELLAH:

A very good example.

WEEKS:

...what the therapist does. I am wondering how the nurse feels. She must feel confused some times.

ABDELLAH:

Undoubtedly. That's a good example, because the therapist comes in and hopefully shows the nurse what kinds of exercises should be done, certainly during the waking hours of the patient. There is the rub. The area of responsibility and accountability around the clock falls on nursing. The clinical pharmacist can come in and out. We have unit dosage. He may even get into some of the teaching. The therapist comes in and out. A nurse is there around the clock. Particularly if we are talking about teaching nursing homes, one of the big problems there is using the therapists as consultants.

They are only in there for a few minutes. It is the nurse who has to be knowledgeable about all of that to provide that care around the clock, or be responsible for it. There will always be that. I think that is one of the unique things that we should capitalize on. That is a nurse responsibility and accountability around the clock for the total care of that patient, so she has to be knowledgeable about physical therapy, has to be knowledgeable about drug regimen and all the other special things that all the other paraprofessionals are bombarding...This is why I feel that one of the unique functions of the nurse practitioner is that she is able to handle this bombardment of the paraprofessionals and synthesize that information in a way that the patient doesn't get to feel, "My, not somebody else coming in again!"

WEEKS:

I am sure they do, especially in the teaching hospitals. There are so many other people coming in.

ABDELLAH:

You are absolutely right. Although it isn't the paraprofessional, the intern and resident is just as much of a bombarding force that the patient is left to deal with. That is difficult, the synthesizing of the information and the interpretation and transmission of skills from all these paraprofessionals or interns or whatever they are to make it meaningful for the patient. That is where nurse practitioners get frustrated. With their paper work and all they don't have time to take over the total needs of their patient. In terms of the nurse practitioner, I think she could do a great deal.

WEEKS:

I see another danger here, maybe I'm seeing something in the woodpile. But it seems to me that I see a trend in the so called paraprofessionals, the

therapists and technicians to upgrade their status to the point where they become professionals. Do you see that going on, too?

ABDELLAH:

Oh, yes, absolutely. They are even having struggles among themselves, like the physical therapists and the occupational therapists. We see the overlap between the nurse and the social worker, and even the nutritionist now. The nutritionist used to be down in the kitchen someplace, not any more. They are up on the units, they are getting involved in diet therapy and teaching. I see the greatest threat though, the clinical pharmacist.

The clinical pharmacist wants to take over the total drug regimen, which worries me because the nurse still has to be knowledgeable about that drug history to pick up some of the synergistic effects and problems and the relationship there. So she says "Oh, that's a drug problem, it is not my business." Then it is the poor patient that is going to suffer. But the clinical pharmacist is still...it's still an in and out, you know.

WEEKS:

You know the trouble with pharmacy is that it is the most overtrained profession for what it does, and it is trying to seek a role.

ABDELLAH:

It is technical.

WEEKS:

I can say that because I grew up, my father had a drug store, and I can speak with some familiarity with their problems and I think it is true that today they are just overtrained for what they have to do. So they are looking for more to do to justify their educational background.

ABDELLAH:

Absolutely, with the Ph.Ds. now in pharmacy...the largest number of pharmacist Ph.D. types are in the Food and Drug Administration and obviously they do assay of drugs and all that stuff. They do a very fine job, but I still have worries about them in the clinical setting. I think it's marvelous that they have progressed enough on the unit dosage and all of that, but patient teaching is something in nursing that we should fight for and maintain.

WEEKS:

I think so too, I think you should have complete charge and responsibility for the patient.

ABDELLAH:

You are absolutely right, the bombardment of the paraprofessionals, and there are all kinds; the inhalation therapists, the IV person, it is fractionating, and the poor patient again is behind the eight ball.

WEEKS:

It is strange, we have an anesthesiologist who lives next door and he has been directing a program in inhalation therapy in our county community college. When I talked with him, I came away thinking every hospital needs at least seventy of these inhalation therapists. Where are we going to end in this thing?

ABDELLAH:

Yes, just like a CAT scanner in every hospital.

WEEKS:

So it gets to a point where it is unrealistic.

ABDELLAH:

I think, Lew, if we could, with threat, visible threat to the nurse practitioner...if we could really define our role, the nurse practitioner

role, as the person who would be there as the constant factor in the health care team, it would be so important.

WEEKS:

We haven't talked too much about nursing research per se, more or less about the training of people. What kinds of research have been done and what kinds should be done, do you think, that haven't?

ABDELLAH:

On that one with the green cover there [refers to a green covered document], Lew, that I think you will find quite helpful. Then I did a later one--that from a historical point of view. There were certain periods, where the social sciences, the behavioral sciences, did quite a lot of work. I identify 1955 as the year when the major federal involvement stimulated research and research training. For about a ten year period, most of the studies were role studies, attitude studies, the kinds of studies which the social scientists, the behavioral scientists were comfortable in doing. So we have those ad nauseum, if you will. The studies which we need to push toward a lot more are certainly all in the area of quality of care, measurement of quality care.

An example of why the nurses were not involved early on in the whole professional standard review organization, I can hear one physician say, "Well, what do you have to offer, what measures do you have to share with us that Miss Jones is providing a quality level of care?"

So that whole area of specific outcome measures, that measure the effect of nursing practice on patient care, is still a big one. Now there have been some inroads along that but it is such a mammoth thing you almost have to break it down by type of patient and diagnosis. But there has been some work

along that line. I do feel that that whole area of outcome measures, criterion measures, in terms of the effect of nursing practice upon the patient, that would be a big one.

We are still at times questioning ourselves whether we are a profession. The thing that still keeps us cliff-hanging is that we don't have enough published in terms of nursing theory and model development. There have been two or three books that I can think of along that line. There has been some very good historical review of the involvement of nursing theory and how that has fed into nursing practice. We need a lot more of that. For example, the whole theory of touch has picked up a lot of momentum in the nursing field. A lot of that started in the nursery with just the holding of the infant, the kinesthetic theory of touch, and then building that in and showing that that contact can mean a great deal in terms of the infant's well-being.

It was interesting that when I visited China and the USSR, it was traditional for those countries for the first six months for the infant to be wrapped around, swaddling fashion, just like a mummy. Yet you go into those nurseries, I remember in the USSR, the strangest feeling, not one infant crying, absolutely dead silence. They were all swaddled, and again it is part of the touch theory, this confinement, this feeling of security.

Things of that sort, we need to encourage much more in terms of theory development, which is specifically nursing, and which could be of help. We can then begin to build up a scientific base and body of knowledge for nursing. We need to encourage much more of that and a whole variety of situations like that.

WEEKS:

You say sometimes nurses wonder if they are professionals. I always look

back at the original, as far as I know, definition of a professional, which is someone who pledges himself or herself, who is willing to devote all his energies and talents to doing something for somebody else, to protect somebody else, to make them better. I think that nurses probably are more professional than any other so called professional, in that sense. They really do devote themselves to doing something for somebody else, caring for them and so on.

ABDELLAH:

Yes, you are right, Lew, but in order to maintain credibility as a profession with others then we really have to show that there is a common body of knowledge, scientifically based and that we do have our own theory of practice, and we have our licensure and so on. But in terms of research, model and theory development, I think it is absolutely essential, that these be related to practice.

Now we have had very little work being done by nurses in terms of animal research. Some, I remember Claire Parsons, who was one of our first postdoctoral fellows, at the Neurological Institute NIH, did some of her early work on sleep using the rhesus monkey. In that whole area, it has been difficult for nurses to get money for any large animal research. They can do it with little mice, rats, etc., but when it comes to getting a rhesus monkey which now costs about $11,000 sometimes up to $40,000! So research is expensive to get the resources.

There has been some very interesting work, Barbara Hanson, you may know her, she was at the University of Michigan, has done some work with animals in relation to the esophageal tubes, in terms of what is irritating to the lining of esophagus and the throat and so forth. Has done some very productive work in changing the whole design of the kind of tube feeding and gastric tube or

whatever.

When I was at the Yale School of Nursing, one of my responsibilities was teaching nursing arts. I remember we had about 107 nursing procedures, some of them really had no scientific base. I think we need to challenge our practices in terms of assuring that they have a scientific base.

WEEKS:

Yes, because the challenge might show that they don't.

ABDELLAH:

I would say, in terms of the priorities, we certainly need the quality measures, the model and the theory development.

Another area, which very often we forget, we have not produced enough historians in nursing, which is why I am rather excited about this oral history today. Mary Roberts, who was perhaps our most able nurse historian, died I guess in the early fifties and there is no one, who has really picked up the mantle on that. We have two or three people, perhaps I could name, who have expressed an interest in history, but they have been siphoned off as deans or in other areas. I think that is a real lack in our profession that we have not trained historians who can really look at what has been done. Without that, we are going to reinvent the wheel.

I can see that in nursing research, we have a number of completed studies that need to be reactivated, but someone needs to take the time to identify those which have promising measures and those which should be replicated. I think in this time of retrenchment of funds, economic funds scarcity, it might give some opportunity to look at some of those completed studies and see which ones could be replicated.

You would appreciate more than anyone else the problems of taking the

average journal and on the basis of what is published there, trying to replicate it. We are just as bad in nursing, I tried to get nurses to at least put a footnote and say "Well, if you are interested in the instrument or in the methodology in more detail, write to so and so." We don't do that, so in our publications, it leaves a great deal to be desired in terms of complete referencing and sharing of instruments, sharing of methodology, or of the sample design. I think we need to do a better job there and then encourage replication. We have a big job ahead.

I mentioned that in 1955 we have maybe under a hundred nurses with doctorates, the number now is close to 3,000. That has been since 1955 and there are many more now moving automatically into that. There are also, which wasn't in existence then, there are also six Ph.D. programs in nursing now, which was unheard of at that time, which says too, there must be some defined body of knowledge in the content area.

WEEKS:

How about the nursing administration course? I know Barbara Horn started one at Michigan and I think she must have one at Washington too, I suppose.

ABDELLAH:

I'm glad you raised that. I guess we, like in other professions, we go in cycles. There was a later article I did on that also. There are certain cycles that we go through.

During the post-World War II, there was a great emphasis on nursing administration and some literature came out during that time, and then there was a great feeling...well, we are getting too much into the management and not enough on direct patient care.

In the international area, I've been involved in a number of what they

call multicountry agreements. There are about twenty-one now that the PHS has, with countries which are interested in learning and sharing technologies, and it works both ways. We learn from them and they share with us, on a quid pro quo basis.

The ones that I have been involved in, exchanges, are with the USSR and interestingly enough, Dr. Roger Egeberg is the one who headed up that official delegation in 1970. I believe it was the first time we went over there. It was during that time that he established the hotline of communication between this country and the USSR.

Initially, it started out in the area of cancer and the purpose of the hotline was that any research which was developing could be communicated before it was published. As you know, it takes about a couple of years delay in publication. That is still going on and there are some very good exchanges there, not only in cancer research but in other areas.

I got very much involved in the USSR in looking at the feldscher, which is a paramedical type person, in terms of the role of the feldscher and how such a person related to our physician's assistant in this country or even expanded role.

WEEKS:

Were they mostly women?

ABDELLAH:

Yes, mostly women. At that time, almost 55% of their physicians were women. Medicine in the USSR is viewed as a woman's role, function. They have three levels of physicians there, and the lesson I had to learn was early on, that you can't link the title--like the nurse title--and say that's a nurse. You have to really look at the function. In the USSR, the first level

physician is really doing what nursing is doing in this country. That person was called a vrosch, a beginning level physician.

Whereas the feldscher was much more like our corpsman or physician assistant type. Nursing was a great disappointment to me, the person they called nurse. I sat in on two or three of the classes there and they have not any of the current literature in nursing, although medical literature was very current. They had the lastest JAMA, the latest New England Journal of Medicine, but were very limited in nursing.

In nursing, they had a text from 1812, teaching bloodletting, that was used in Washington's time, and the use of leeches, and that was the lesson of the day. As they do in China, during the break of the class, they were expected to sweep the floor, do the housekeeping, or whatever, in the classroom.

So nursing was a great disappointment, it was essentially an apprentice type, but very limited over there. In the Russia, nursing was always under the physician, and the physician was the one who examined the nurse. The physician was the one who determined whether or not she, and it usually was she, was ready to go on.

Nursing was viewed in the Russia not as a profession, but only as a basis for learning and if you were good, for two years as a nurse, then you MIGHT have a chance--a chance--that you might enter medical school. So it was viewed as an interim step towards a medical career, but not as a career.

So that was a great disappointment. I even had the opportunity to ride in the ambulance in Moscow one night. You know, with their emergency service that could guarantee...you could dial a two digit number and you could, within ten or fifteen minutes, get their emergency care. Most of the time, it really

did work. They have introduced in some of the Scandanavian countries, a penalty for payment. That is, if you just had a stomach upset or if you had a headache or something, or if you didn't feel that in the cold weather you wanted to go into the clinic, then they would charge you for the visit. But if it was a serious thing and justified, that you would not have to pay. So they do have some restraints on it.

I did get back one time later to follow up in the USSR, then we moved on into Yugoslavia when I was with the National Center for Health Services Research. We had a lot of research studies going on in Belgrade and Zagreb and some of the other parts. The interest there was primarily in models of health delivery, and it provided an opportunity to look at different approaches for testing out models of health delivery, and also training, patterns of training. They had a lot of interest and support in Yugoslavia for that.

Then my trip to the Republic of China, that was just about two years ago, I went over with a non-federal group. We were looking at the care of the elderly. Of course at the time, I had been very much involved in long-term care and care of the elderly. We thought "Gee, this will be great to see what we can find out." To my knowledge, we were the first group to specifically go over to look at the care of the elderly.

First of all, it was hard to find the elderly, because China is a very young population. Two years ago they said something like 2/3 of the population would be well under 40. A very young population. But they just didn't live because of the nutrition and so forth. They just didn't live long enough. They don't have institutions for the elderly there, so the only place we could find any elderly would be in the so-called communes.

A commune is made up of about 40,000 people. They are really responsible for production of their own food, through agriculture primarily, obviously.

They have a 40,000 group in which would be about two or three clinics covered by these barefoot doctors, who used very young girls, 26 or so, trained at first-aid, a first line attack kind of thing, immunization, preventive care, and that kind of thing. They used all traditional medicine. The only thing of Western medicine was the aspirin, but everything else was herbs and medicinals and acupuncture, of course.

We were so excited, I remember, when we did find a few older people. They were living in a small cabin, as independent, they even had their own little garden. They were responsible for participating in the commune and being a part of that, and they kept active.

In Shanghai, it was during July, like now, hot...96, no refrigeration and there is no pasteurization or anything like that. We noticed these elderly people in this hot, humid weather, carrying this huge big placard, marching down the street. The interpreters said that it happened to be the hygiene campaign for two weeks. We asked them why they used the elderly when it was such a hot day. "Why don't you have some of the young people do that?"

They said, "Oh, no, they use the elderly because they are revered and if they carry this message, the young people will read it and pay attention." It said very simple things, like cook food right away or don't spit on the street. So it was very directive, very short things about basic hygiene. But again they used the elderly, and in the Soviet Union, they use the elderly there as a part of the family.

When the younger people are at work, the elderly have to stand in line and wait for their daily rations. So they had to go from one line up to another

line up. They spent the whole day just picking up the groceries.

So you can see why the supermarkets really do drive the Chinese crazy when they get over here.

In China, we were trying again to establish some exchange programs and there is an official Chinese delegation coming over here a little bit later this fall. Their interest is in technology exchange rather than...we were trying to get the Chinese to visit some of our National Health Service Corps sites in the rural areas off in Vermont, or Appalachia, or at Albuquerque. No. They wanted to go to Harvard, Yale, some of the name places they had heard about. Oh, no, they couldn't go home without going to Harvard, but we didn't want them to go to Harvard, because we wanted them to see something that they could take back home. But they still will dictate what they want. They want to look at the CAT scanner, they don't have a CAT scanner, they want a CAT scanner. Typical, huh?

So we have a number of multilateral programs, very active in Egypt now. A group that has been very interested in health, the Nigerians, they have a lot of money now, and they have given health a priority in that country.

I have had the privilege of participating, through World Health Assemblies, which meet in Geneva...WHO, yes...that is the policy body, part of WHO. It is very hard to get on these delegations, because very often the appointments are political. The agenda items are structured pretty much a year ahead.

If we are not a part of the delegation, we do work with our office of international health and the areas. For example this past spring. I did not get to go on it, but they had an area on primary health care, health for all by the year 2,000. I got involved in background information on that. There

was one on mental health, one on nurse midwifery, another one on The International Year of the Disabled and then they always put on one in furthering women, you know.

But we have a chance, even if we are not on the delegation, to prepare the background documents for whoever goes over there to present the information. Two years ago, it was very exciting, in that I was given the responsibility for developing and introducing with member countries support the World Health Congress, which will be in '82.

What this meant, in developing a resolution, you have to really interview a number of countries and making sure you have both developing and developed countries, to get their point of view. I was disappointed in that very few of the developing countries, like Kenya, and Nigeria...they weren't too interested in the elderly because they don't have that problem, yet. So it was hard to get them to see, that twenty-five years from now, they were going to have that problem.

WEEKS:

Do they consider it still a family problem?

ABDELLAH:

No, no, they consider that they have essentially a young population, you see, so they...they say they have alcohol problems, they have drug abuse problems, they have malnutrition problems, they have polluted water problems, they have road accidents, and it is..."Oh, let's talk about all those things." But you try to talk about the elderly. Of course, the Scandinavian countries have been very much in the forefront in the care of the elderly, so there is a lot of good interest there. But it was quite hard to get these developing countries interested and willing to counter or to cosponsor the

resolution. I got a few, but not as many as applied.

This congress that will be developing in '82 is going to tie into the White House Conference on Aging which is this November. So I have had a full time staff person working on that and then we've been getting quite a bit of input into that.

Now the White House Conference on Aging is a ten year plan and that will fit into the International Congress and serve as the U.S. plan for the World Congress on Aging. So this is essentially our blueprint recommendations for that so that will fit in. It has been very exciting to see the broad range of problems dealing with the elderly: housing, nutrition and financial, as well as all the research going on.

Dr. C. Everett Koop is our Surgeon General; he is very much interested in the International.

At the moment, there is not too much interest in this administration in international health, because they feel that is a luxury and that we should just worry about the home concerns. I think it is unfortunate, in that I think we need to be aware of the international, and I do feel that we can contribute enormously.

It was in 1980 that Secretary Harris announced for the World Health Assembly, the eradication of smallpox, which was a very exciting event. Now they are trying to work the eradication of measles.

As a historian yourself, the answer to the cause of smallpox was known one hundred years ago, but it took one hundred years to get it eradicated throughout the world. Which shows it is not just the facts you have to have, but you have to have the readiness of society, willing to say that we want to eradicate smallpox, that is a priority for us and we will allocate the

necessary resources and funds and so forth to do that. That is why it took so long, the political issues come in there, and the social issues come in there, even though you know how to eradicate smallpox.

WEEKS:

We even had pockets of it in this country around World War II, I remember we had an outbreak in Detroit. I lived in Detroit then. There were six or eight cases in that one small area.

Do you think that if there is less interest in preventive measures, is it because, maybe, we believe there isn't much to be prevented anymore? You know, we have gotten rid of polio, we've gotten rid of smallpox, and maybe measles.

ABELLAH:

When you look at Healthy People, the Surgeon General's report, I believe there are eighteen things that we could prevent. Many of those, we ourselves can prevent, like the alcoholism, smoking, hypertension, some of the behavioral things, perhaps. So we have knowledge about some of the things that we could prevent.

One of the shocking things for me to realize, too, is that health is not a priority of all, of everyone. Not everyone cares about being healthy. They would rather be happy and free and smoke and drink, and to them that is their quality of life, you see. What we interpret as quality of life may not be. So we have the answer there, if we could get it across.

Prevention is costly, initially, you know. Congress wants their constituents to see the results within the four year period. With prevention, you can't always do that. It is very difficult.

I know when we try to get these national hypertension projects going,

offered free services and taking blood pressure in various industries, the unions fought it. The unions and some of the major industries, because they couldn't see allowing people off time to get their blood pressure taken, that was lost time from work and because hypertension is something you live with all your life, unless, you can, like diabetes, get it down. You don't have any overt symptoms initially, most of the symptoms are not. So it is really hard; you have to work hard to get the people to be concerned.

WEEKS:

To realize the real and present danger.

ABDELLAH:

Yes, there are so many things, drugs, glaucoma, ulcers, there are a lot of conditions now. We think...Well, polio is still a problem in some parts of the world, tuberculosis is still a problem, venereal disease is popping up again. Our Centers for Disease Control in Atlanta, their big push is on measles, the rubella type, because of its devastating effect on the pregnant woman and the effect upon the child. So those are the things, but if we could eradicate that.

So we are after measles this year. There is going to be a big health survey conducted by our department, the PHS, based on that Healthy People report. I don't know how successful it will be. It is going to be a self-questionnaire. It is going out all over the country, and I'm not sure how effective it is going to be. They are supposed to measure, try to get some assessment of health, what the individuals see as priorities, because people will dictate what they want in terms of health care and what they want the government to do, or the state to do. So it is up to the people.

WEEKS:

Yes, I'm afraid that there is a point beyond which we can't go as a doctor or...

ABDELLAH:

Like smoking, we can only say well this is the best information. As an individual, this is your choice. The freedom of choice.

WEEKS:

But nevertheless society has to pay a price for it.

ABDELLAH:

Society pays a price. We pay price in terms of the long-term effect of the emphysema and all the rest of it. Eventually it does affect all taxpayers; there is no question about that.

WEEKS:

But I don't think we can do much about that.

ABDELLAH:

I do think we have a responsibility, worldwide, in sharing what information we have, particularly in prevention. I have been very much involved in the International Year of the Disabled this year, responsible for that in the PHS, and in our Communicable Disease Centers and also at Carville Leprosarium. They have developed packages, for example, on Hanson's disease, on training modules, written materials and they are translating these now into several languages.

Then at the Communicable Disease Center, they have several of the common diseases, schistosomiasis and some of those things, where there is a whole package of training materials translated into different languages.

I feel one of our greatest treasures is simply the research capability there, the people with the research capability. I think we have a

responsibility to continue to share that.

WEEKS:

I would think so. It is probably one of the best goodwill gestures we can make.

ABDELLAH:

Yes, when you visit countries like the Soviet Union or China, as long as you talk about health it is marvelous, you know...no problems, stay off the political theme. It is only recently that health is getting into the political arena, like infant formula, where our country got very much involved in that. This was a political decision rather than a health. Unfortunately, health has gotten into the political arena.

WEEKS:

Who bought the formula, where did the money come from that bought the formula that was used in Africa?

ABDELLAH:

This was the company's, Nestles, is that what you mean?

WEEKS:

I was wondering who paid for it or was this a contribution on their part?

ABDELLAH:

You remember before cigarette smoking was restricted so much on the planes, they used to give you a little cigarette package, well they did that with the infant formula. One of the code things that they prohibited was having health workers dress up, like with a nurse's uniform, with the cap, and go around and peddling. The code was meant to be, these were guidelines meant to guide countries and again WHO operates in a way...they don't make anything mandatory, they say this is a guideline, you take it or leave it. So I think

it was unfortunate that it was misinterpreted to be much more than it was.

I just learned the other day, really to compound the issue, this is also the hundred year anniversary of the American Red Cross. The commemorative stamp which came out showed a Red Cross volunteer with a nurse's cap on, holding an infant and holding a bottle. So then again it just portrayed, symbolically, the very thing the code was saying that countries should not be doing. So the timing, although stamps take about two years to get approved, so the timing couldn't have been worse.

We had an international visitor here the last two days from WHO and she said we have lost a lot of credibility. But in the federal government, you have to vote the way the administration says you vote, the State Department, regardless, so it was a political vote, a political decision. But we did lose a lot of groundwork. Countries just don't understand, you know.

WEEKS:

You want to talk about Secretaries a little bit?

ABDELLAH:

I really didn't get to work closely with the Secretaries until 1970 when I got elevated enough, because otherwise I was just one of the troops.

So Oveta Culp Hobby was just a name. Elliott Richardson was in in 1970 and that was only for a short time and there was a change. He...everyone always admired him as being very much a scholar and a leader and really a very great person, a great benefactor.

I guess of all the Secretaries I worked with the most closely was Secretary Weinberger, and particularly in relation to nursing homes and long term care. And his deputy, Frank Carlucci. You know both of those are now over at the Department of Defense. Both of them very, very fine leaders and

I'll always feel very privileged to have worked with them.

Then following Weinberger was Secretary Matthews, an educator from the University of Alabama. A very young man, but played a minor role. He had a deputy, Lynch, who subsequently died, a very great lady...that's her picture over there, Marjorie. She was very active in the state legislature in the state of Washington. And then, when we had the bicentennial, when we had the 200 year anniversary, she got involved in that and then became undersecretary. That was a lot of fun. I had an appointment to work with her, a very great lady.

Then Califano, his style was quite different, if you've had a chance to read his memoirs. He loved to be much more outspoken and he really wanted to be known as the #1 health official, rather than the Surgeon General. We did have one then with Dr. Richmond playing the dual role as Assistant Secretary for Health, but Califano was always the one out in front, being the spokesperson.

Then Secretary Harris was on, a very able, certainly very strong legal mind. So she sort of became the last HEW Secretary and the first Health and Human Services Secretary. A very brilliant woman in that...a lot of fun to work with in that she could grasp the issues right away and had a very broad picture of things and a very, very able lady. She was very good.

The average life span of a Secretary of our department has been one and one-half years. So that is why we have had so many since 1953...a very short lifespan.

WEEKS:

Yes, it has been. I think Arthur Flemming is still alive, I'd like to talk with him sometime.

ABDELLAH:

Would you? He is just great. I'm glad you mentioned him, because of his interest in aging, we worked very closely together for about four years on that. I think he is a very great man. I would measure him with really the top people. I got to know him not so much when he was Secretary but when he was the head of the Administration on Aging and was very much involved in the whole civil rights area. Tremendous person. He is still very active, is on the National Advisory Council on White House Conference on Aging. Tremendous person, I hope you get to meet him. He just lives over in Alexandria, very approachable.

WEEKS:

I would like to see him this fall if he is available.

ABDELLAH:

He will be very busy through November, because of the White House Conference on Aging.

WEEKS:

I felt Secretary Flemming was in a very bad position in the days when he was Secretary because there was so much movement toward Medicare. I think he really favored it but he couldn't take the official position.

ABDELLAH:

That was Wilbur Cohen's time, wasn't it? That was interesting. He was the actual pen on the act, 1965 or 1966.

WEEKS:

I have also interviewed Wilbur Mills which was very interesting, too. Because I found that in talking with politicians, they are very cagey about how they talk.

ABDELLAH:

Oh, indeed. They have learned the hard way, haven't they? I must say that I would have to put Secretary Weinberger very high on my list.

WEEKS:

He has always impressed me from seeing him on television and reading about him in the newspapers.

ABDELLAH:

A very fair person. I quite frankly have not gotten to work closely with Secretary Schweiker. His style is to have more people, more layers around him, whereas Weinberger didn't like many layers between him and the troops, so to speak. There are many, many layers now between even our own Dr. Brandt, who is Assistant Secretary for Health. There is now for the first time a physician heading up planning and evaluation, so there is another physician between Dr. Brandt and Secretary Schweiker. So we have more multiple layers.

But Schweiker is verbalizing his support for prevention and research, so that is very encouraging. I think he takes over at a very difficult time and is going to have to fight some very tough battles, like Social Security and the trust fund. A very able person, no question about it. So I may have a chance at some point to work more closely with him.

WEEKS:

Did you want to mention more about the National Center for Health Services Research?

ABDELLAH:

Yes, I would like to.

As I mentioned while we were chatting a little earlier, we were very fortunate to have the forward leadership of Paul Sanazaro, a man much before

his time, and his ideas. It was really a postgraduate education to me to work with him. We would have, I guess every week, some brainstorming sessions. It could really pique your imagination to really come up with some creative ideas about health services delivery, various research efforts, training. I would say my years in the Center were very thoughtful in terms of opportunities to think about new ways of trying, and the approaches.

I think that was the most exciting part, it was under the National Center that we were able to get support for the first Primex projects on the expanded role. We looked at early support for different models of delivery of service including in rural areas, which was then the forerunner of National Health Services Corps, which I mentioned, of the HMOs, the PSROs and the Emergency Medical Services.

All of those were early models which were talked about and fostered and supported on an experimental basis and then fullblown. So that I would put Sanazaro very high on my list of very special people that I had the privilege to work with, in that you learned and you stretched your thinking to the utmost. Very challenging...and very great man, and he surrounded himself with a lot of able people, like Evelyn Flook and Eichhorn and some of the young people. He was a marvelous example for some of the young scientists coming along, stimulating. That was a very special experience in my career and I learned a great deal from that.

Now, on some books?

My first adventure was with the so-called twenty-one nursing problems, patients, and approaches to nursing. I got into that because, again it was my early thinking in relation to a form of grouping patients by common problems and identifying what those problems are. There was a publication in 1950. I

think is still being used, and a great deal in foreign countries, where they are searching for something to bring cohesion to the curriculum and how that might come about. I was just last week at the International Congress on Nursing, which meets every four years, and they met in Los Angeles. The first time they met in the U.S. in 37 years. I met with a lot of nurses from Japan and they have translated that into Japanese and it is still used over there.

We did a sequel to that called "New Directions and Dimensions in Nursing" which was not as popular but it was more useful in this country than it was in other countries because it took examples of the two year diploma and four year program and showed how one could integrate this common patient problem approach to that. I always joke about that twenty-one problems kind of thing because for nursing it was a sort of Larry Weed approach, problem-oriented record, if you would, in nursing. Although this sort of focused on the total problem and not the patient. I guess that is how I got my feet wet with that.

Then came the Better Patient Care Through Nursing Research, in which I collaborated with Eugene Levine, a manpower specialist, a statistician. That was an exciting thing to do in that it's been encouraging to see that it is used a great deal at different levels, not only nurses but by others, too, so that is encouraging.

WEEKS:

I find it a good source book to dip into when there is something I need.

ABDELLAH:

Then as a result of the progressive patient care, I got to work with Larry Meltzer, a cardiologist at the University of Pennsylvania, who was very much interested and he set up some of the early coronary care units. And I collaborated with him. Well, he on his own had started to do a cardiac care

manual, training manual, and then we did one together, a multidiscipline approach to looking at intensive care broadly, not just heart disease, but others.

That book is still useful, it needs to be revised. That is always the worst about a book once it gets out, you know, to think about the revision. He is revising the manual and we need to update the book, for things have obviously changed radically.

I guess then the other monograph that was useful was The Effect of Nurse Staffing on Patient Care, which was an attempt to look at staffing configurations, and hopefully, lay the groundwork for some basis of developing outcome measures in relation to patient care.

I've really loved my career in the Public Health Service. I've had some wonderful opportunities and exposure to people I've found very stimulating intellectually and just to help you think beyond the next horizon and to new directions.

Dr. Koop and I were chatting the other day. He has great interest in the whole area of prevention, the elderly, and the disabled. You know, looking at those three components, that covers a whole span of things we could get interested in, impact on. He is a very compassionate, very kind person, and a fighter. He will be a real leader. It is not easy for him as you can imagine. I hope his appointment is confirmed.

WEEKS:

Shall we review fee-for-service?

ABDELLAH:

By fee-for-service, do you mean direct reimbursement?

WEEKS:

I mean for a surgeon to do an operation and get a fee for it rather than to work on a salary like they do in Cleveland Clinic. All their surgeons work on salary. So it doesn't matter whether he operates or not, he gets his salary. There is no inducement to do surgery to make money, in other words. Maybe that isn't a fit question to put to you.

ABDELLAH:

I am really not in a position to make a judgment on that except if you give them just a salary, I suppose they would say that was socialized medicine.

WEEKS:

I'm sure they do, but at Cleveland Clinic, I'm not sure how many people they have on their staff, but they have a 1,000 bed hospital, so they must have a lot of them. Ford hospital also works on a salary.

ABDELLAH:

So it would cut down on the amount of abuse, wouldn't it?

WEEKS:

This is it. Dr. George Crile of Cleveland Clinic uses the term "inappropriate" surgery rather than "unnecessary."

ABDELLAH:

We were very pleased to see the support for the second opinion. I think that has been a tremendous help in cutting back on unnecessary surgery. I haven't really gotten involved too much in that, only in relation to nursing where we are fighting about the direct reimbursement which is a real controversial one.

Do you want to hear about hospice? I got involved in hospice as a concept of care, which could occur in a home, or the institutional setting. Califano was our first Secretary who got really interested in that, as a part of

long-term care. Credit is due to him in that he did encourage and did approve support of demonstrations of hospice care.

The National Cancer Institute, was the first to get involved in the support of hospice care in this country, patterned after St. Christopher's in London. There was a lot of criticism in that the feeling was that hospice care should be available for any terminally ill person, not just cancer patients. With that in mind, the demonstrations we set up were set up in a way to open it up so that it isn't just for cancer patients, but could include other patients.

Also, the demonstrations are in different settings. There are twenty-six demonstrations. Some are free standing like the first one up in Branford, Connecticut. Others are like St. Luke's in New York, which is a unit within a hospital, and some are like Health Haven, which are actually within a nursing home area. So there are several factors we are looking at in terms of what kinds of services are needed and the importance of bereavement services, and how long they should be provided.

We are looking at cost factors and there is a whole dimension in relation to drug therapy. Also issues in relation to the sequence of a person requiring hospice care. We have found that we need to keep an open door on a hospice type facility. One just doesn't go in there and say that's the end. One might go in for a couple of weeks and come out so it's a back and forth kind of thing. So if you had a community-based or home-based support system, it is quite possible for that person to stay at home and then at certain periods, may have to come in for care.

Hopefully, these demonstrations will run for about three years. They would provide some basic information about the kinds of services the federal

government should provide or states should provide or philanthropy should provide. I do think though that as a concept, it is important. I, as many others, have concerns about setting up a McDonald's one way approach to it, but I'm sure there would be multiple approaches.

A social worker and another nurse collaborated with me in developing some guidelines for hospice. The intent of that was to make it available to the health professional schools so that they could be encouraged to include this approach to terminal illness in the basic curriculum. That has not been published yet. I have to check on that, it would be of some use, at least to stimulate thinking along the line and get it into the curriculum.

It is not unlike the approach of the teaching nursing home that if you expose people to the concept and got them excited about it, this might hopefully interest them in choosing that for at least a segment of their career. So it is very interesting. You don't hear as much about it as you did a couple of years ago. But I guess it is because it is being interwoven into the system.

WEEKS:

Yes, I think it is that and maybe it needs a Readers Digest article or something of this sort, look how holistic medicine has taken off, in its many forms.

It has unfortunately become a tag that even charlatans have picked up. But it would seems that this hospice movement is an excellent idea.

ABDELLAH:

There have been some excellent articles written by members of the family, that they experience this type of care and I think that has been very encouraging. There is a national hospice organization that is based over in

Virginia and I have joined that as an individual member. That organization has done a lot to establish standards of practice and standards in terms of types of hospice, what would qualify as such. We were very concerned about the charlatans taking over it and saying that they were a hospice and really just offering no services at all.

We have been fortunate to have Dr. Cecily Saunders visit us a few times, the lady who developed this whole concept at St. Christopher's in London. She is an interesting person who started out as a nurse, became a social worker and then became a physician. So you have the three disciplines there. Marvelously, she was given one of the highest honors by the U.K., a certain medal for her contributions and was given the award recently.

WEEKS:

Being a part of the three disciplines gives her a broader perspective of things.

ABDELLAH:

I guess she started out as a social worker and then became a nurse. But the problem she ran into in nursing was that she wanted to experiment with different drugs in relation to pain and she realized she had to get the M.D. to get any place with the drug experimentation. So a good part of the regime and the care of the terminally ill at St. Christopher's, as she has developed it, is that they do use morphine and heroin and all that and they have worked out, through her study, to provide medication before the pain occurs. So they don't wait until you have the pain, they have estimated the threshold of pain and then they monitor the patient very closely. So it isn't that these people live any longer but they are as free from pain as possible so that the quality of life is there.

I'll never forget visiting St. Christopher's and seeing a twenty-two mother of a two year old. The English in their very gracious way...St. Christopher's is set up very home like, opening out onto a beautiful English garden. This twenty-two year old mother was playing with her two year child, as happy as if there were not a care in the world, and she died one week later. I have never forgotten that picture of her. Absolutely happy, free of pain, but terminally ill and the freedom to be playing with this child.

It gives you something to think about.

WEEKS:

If I may interject a little story here.

Studying nursing units, did you read Ann Cartwright's study of patients attitudes toward nursing units in England? She was trying to determine the optimal number of beds in a room. The answer came on something like this: In a private room, you'd be lonely; two beds, you might not like the other person; three beds, two of you might not like one; so four beds would be optimal, because there surely would be somebody that you liked.

ABDELLAH:

Very practical. These demonstrations of hospices now have been running about a year and a half and the evaluation going on simnultaneously, so I'm hoping that we do at least define what services should be provided, get a better definition of bereavement services, look at the whole pain area in terms of pain therapy, and hopefully, open it up, regardless of age, to any terminally ill patient--with the goal of providing a quality of care, quality of life. It could be very rewarding.

WEEKS:

You were speaking of mental health and geriatrics as being two of your

interests.

ABDELLAH:

I have been less involved in the mental health aspects, I have gotten involved in mental health and the elderly, and have been somewhat involved in that the National Institute on Mental Health has a division that is very much concerned with the mental health of the elderly.

The aspect that I have been very much interested in is those senile dementias that might be attributed to old age, which are reversible. The National Institute on Aging now is supporting quite a bit of research in relation to Alscheimer's disease which is a kind of a catch all for senile dementias.

We have found from our own research that the average patient in the nursing home receives five tranquilizers and you combine that with poor nutrition and it doesn't take long before that individual could fall into the category of being senile. So a lot of the so called senility is senile dementia problems.

There is information that is beginning to emerge that they are reversible. That some of them are nutrition caused, some of them are certainly the over-tranquilization and the synergistic effects of drugs, the parallel problems of slow absorption on the part of the elderly, and the different absorption patterns of drugs.

So there is that whole avenue of pharmodynamics opening up.

When Mr. Carter was in, through that administration, I got involved in some of the development of the mental health systems act. It is milestone legislation and covers training, research, and particularly community centers for the elderly with mental health disturbances. Congress, this year, I

believe, will support one more categorical year for that before it becomes a part of this block grant package. The legislation was just signed in early November, by President Carter, so it really did not have any implementing legislation or guidelines. It would take a lot of that before it is ready to go.

If it ever gets implemented fully, it could be milestone legislation for the mentally ill that could affect particularly the service delivery and the training of professional in relation to that. But a lot will depend on whether it gets off the ground or not.

I did get involved with the disabled as part of the International Year of the Disabled, and the mentally retarded. There has been a lot of interest in that whole area in relation to the mentally retarded. In terms of prevention, another controversial issue whether the whole area of genetics and the use of amniocentesis and the early identification of some of the genetic problems.

So you get into the realm of bioethics, and all of that is an issue.

WEEKS:

The abortion problem all over again.

ABDELLAH:

That's it. The FDA was already to release a package to be used only by physicians and encourage the early scanning of what they call neural tube defects of these infants, where it could be a very small, not unlike amniocentesis, small skin puncture, getting some of the fluid from the vicinity. One could detect through laboratory analysis the genetic combinations. That is being held up now with all the feeling of the pro-life groups. So you mentioned that article earlier, when does life begin. That is one thing that no one is in agreemnent on, that is for sure.

WEEKS:

It is a very personal problem.

ABDELLAH:

We are concerned though that in the care of the elderly that not enough attention is given to the disabled elderly or to the mentally ill elderly. In our mental institutions, the elderly population is increasing. It is very high, and there is not enough attention to that.

WEEKS:

It is not so easy to put them on thorazine and send them out into the world, there is no place for them to go.

ABDELLAH:

So much to do.

WEEKS:

Thank you for the interview, we have covered many interesting topics.

Interview in Rockville, MD

July 10, 1981

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